



FEDERAL PROPOSALS TO RESTRUCTURE MEDICAID:

WHAT COULD THEY MEAN FOR CONNECTICUT?

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OVERVIEW

Changes to the Medicaid program are under discussion at both the state and federal levels. Much of the interest in Medicaid restructuring arises from increases in Medicaid costs following a period of relatively slow growth. In fiscal year 2004, Medicaid spending nationally is predicted to rise by 7 percent. Connecticut's Medicaid expenditures, which historically have grown lower than the national average, are projected to grow by 8.7 percent in FY 2004.¹ States have been confronted with this increase at a time when state revenues are declining sharply. A recent review of state budget actions found that states have responded in a variety of ways — including reducing payments to providers, eliminating services, increasing cost-sharing, and, in some cases, reducing eligibility for the program.² A few states have not made significant changes in their Medicaid programs, choosing to maintain their recent coverage gains and improvements.

Medicaid serves as the nation's primary public health insurance program and, especially in times of recession, as the nation's health care safety net.



Declining state revenues



CT Medicaid's rising expenditures

Medicaid's cost increase closely mirrored the increase in premium costs in the private sector, yet much of the growth in Medicaid costs in 2002 came about because the program served more people.³ Medicaid serves as the nation's primary public health insurance program and, especially in times of recession, as the nation's health care safety net. In addition, a growing share of Medicaid costs stem from its role as a backstop for the shortcomings of the Medicare program — providing prescription drug and long-term care coverage that Medicare does not offer. Medicaid is a joint federal-state program with the federal government on average paying 57 percent of the costs, and states administering the program within general federal guidelines. Medicaid is also the largest single source of federal funding for states, and these federal funds help stimulate the local economy. In FY 2003, Connecticut will receive an estimated \$1.9 billion in federal funding through the Medicaid program.⁴

Given the growth in Medicaid costs, policymakers are looking for ways to reform the program. Perhaps the most prominent of such proposals so far is contained in the Administration's FY 2004 budget proposal. The proposal would restructure many of the core features of the Medicaid program and offer states a limited amount of upfront funds in exchange for accepting a ten-year cap on federal Medicaid spending. This cap would apply to approximately two-thirds of Medicaid spending nationwide — spending for persons and benefits that fall into "optional" categories under federal law. For states that choose to participate, the capped "allotment" structure would replace the current system of open-ended federal funding. Some states, such as Connecticut, would see a higher percentage of their funding fall under the cap because a larger proportion of their spending falls into the "optional" categories. The Administration's proposal also eliminates the State Children's Health Insurance Program (SCHIP) [in Connecticut "Husky B"] for participating states by rolling SCHIP funding into the revised Medicaid program.

Governor John Rowland was an early and vocal supporter of the Administration's proposal. In testimony before the U.S. House Congressional committee with jurisdiction over Medicaid, Governor Rowland described the Administration's proposal as a "home run."⁵ But at its winter meeting in February 2003, the National Governors Association (NGA) declined to endorse the Administration's proposal largely because of concerns about the cap on federal funding. Instead the NGA formed a bipartisan Task Force to consider alternative approaches. Governor Rowland was appointed to the Task Force along with nine other Governors — five from each party.⁶ After much deliberation, the Task Force was unable to come to a bipartisan agreement.⁷

The high stakes for all states and their residents inherent in any major restructuring of the Medicaid program underscore the need for careful analysis and reflection.

This report examines how Connecticut would fare under the President's proposal, and briefly considers alternative approaches.

INTRODUCTION

Medicaid currently serves 51.5 million people across the country. This includes 25.9 million children, 12.7 million parents, 8.2 million people with disabilities and 4.8 seniors.⁸ In Connecticut, just under 400,000 persons receive their health care through Medicaid — 75 percent of these enrollees are children and their parents, the remainder are seniors and people with disabilities.⁹

Medicaid serves as a vital health care safety net for these persons by providing comprehensive, low-cost coverage. In addition Medicaid provides long-term care, including nursing home care and community-based services for seniors and adults and children with disabilities, and acts as an important supplement to the Medicare program for low-income Medicare beneficiaries by providing prescription drug coverage and paying Medicare cost-sharing.

People with disabilities and seniors constitute 27 percent of the beneficiaries but account for 82 percent of Connecticut's Medicaid spending.



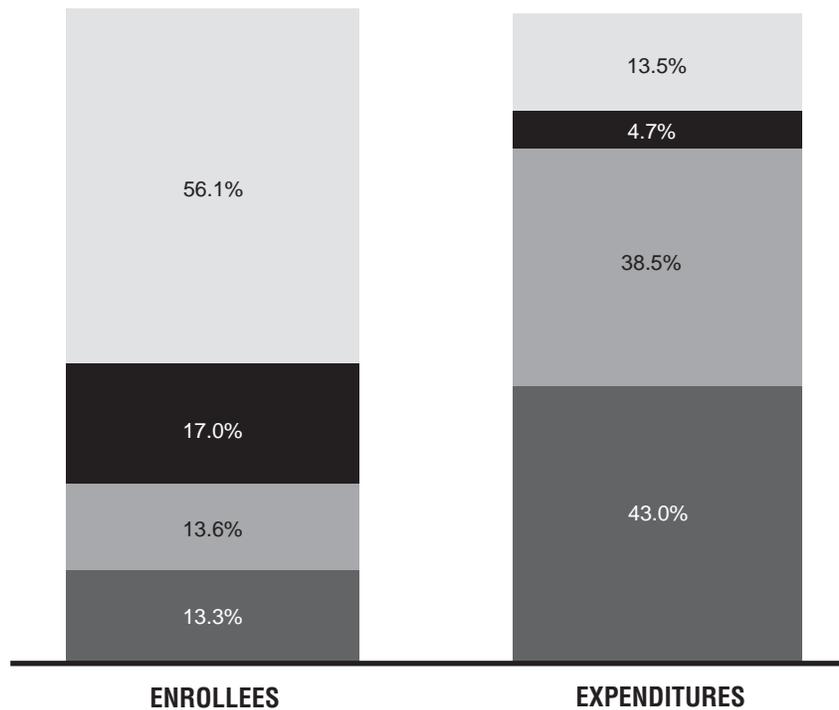
Who does Medicaid serve?

By far, the single largest group of Medicaid beneficiaries in Connecticut and nationwide is children. However children and their parents are the least costly beneficiaries. While low-income children and their parents comprise close to three-fourths of

Connecticut's Medicaid beneficiaries, they account for less than one-fifth of total spending. People with disabilities and seniors constitute 27 percent of the beneficiaries but account for 82 percent of Connecticut's Medicaid spending.¹⁰

Figure 1

Elderly and Disabled Account for Most of the CT Medicaid Costs

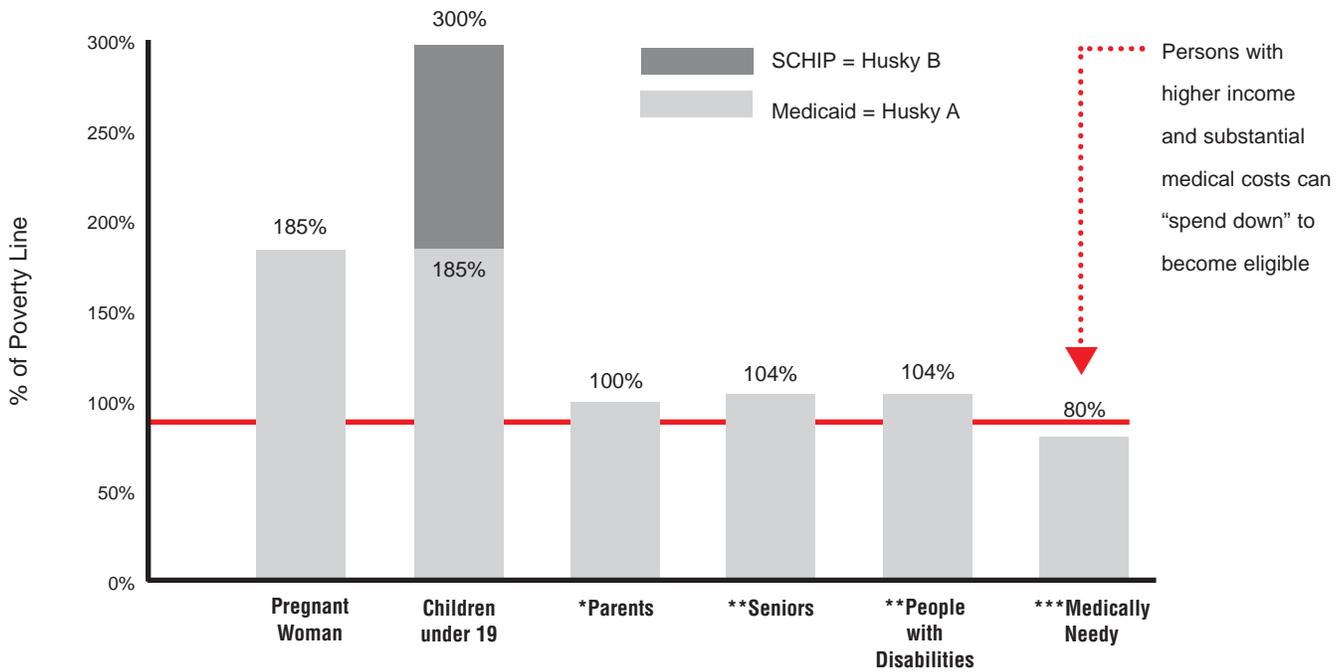


Source: Centers for Medicare and Medicaid Services MSIS data, 2000. Data for 2001 in Connecticut is incomplete.

Children Adults Blind/Disabled Elderly

Figure 2

Income Eligibility Standards in CT for Medicaid by “Eligibility Group”



* Eligibility for parents was lowered from 150 percent of Federal Poverty Level (FPL) to 100 percent effective April 1, 2003.

** Source: Aged, Blind, and Disabled State Summaries, National Association of State Medicaid Directors, based on standards in effect on October, 2001 (see www.nasmd.org/eligibility).

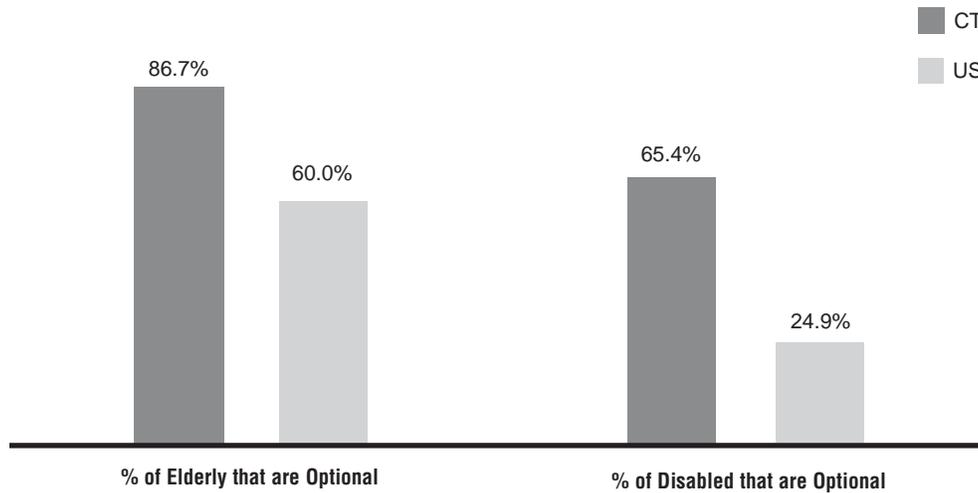
***Income levels for medically needy vary based on regions in CT. The medically needy income level in the most populated region in the state is 80 percent.

Medicaid beneficiaries and services fall into two categories — optional and mandatory. For example, states are required to cover children ages 6-18 years whose family incomes fall below the poverty line, and younger children must be covered up to 133 percent of Federal Poverty Level (FPL) [\$20,296 annual income for a family of three in 2003]. Almost all states, including Connecticut, have chosen to cover children through Medicaid at higher income ranges — these children receive so-called “optional” coverage. Connecticut covers pregnant women and children up to 185 percent of FPL through its Medicaid “Husky A” program — for a family of three this equates to income under \$28,232. Children above the Medicaid income levels are covered up to 300 percent of FPL in Husky B, the state’s SCHIP program (for a list of optional and mandatory groups see Appendix Table 1).

Approximately one-third of all Medicaid beneficiaries nationwide are covered through optional categories. Connecticut’s Medicaid program includes a higher proportion of optional beneficiaries — especially with respect to people with disabilities and seniors. Across the United States, 25 percent of people with disabilities are covered through optional categories, but in Connecticut 65 percent are optional — more than two and a half times the national average. Similarly seniors are covered in optional categories at a much higher rate in Connecticut than the national average — 87 percent compared to 60 percent. In Connecticut virtually all nursing home residents — 98 percent — are optional beneficiaries.¹¹

Figure 3

CT has Higher than Average Numbers of Optional Elderly and Disabled Beneficiaries



Source: Centers for Medicare and Medicaid Services MSIS data, 2000.

What services are provided through Medicaid?

Medicaid requires a comprehensive set of services for children — known as the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit and a more limited set of services for adults. Prescription drugs are an optional service for all adult beneficiaries (for a complete list of mandatory and optional services see Appendix Table 2). Other commonly provided optional services include prosthetic devices, hearing aids, vision and dental care. Nationwide, 90 percent of overall Medicaid long-term care expenditures are considered optional. For adults, the Medicaid benefits package is similar to major employer-sponsored packages with the addition of benefits like long-term care and other services needed especially by seniors and people with disabilities that private insurance typically does not provide (see Appendix, Table 3).

How is Medicaid financed?

Medicaid is jointly financed by the federal and state governments. It is an open-ended, federal funding source based on a matching system. For every dollar that a state spends on health care services that comports with federal Medicaid requirements and options, the state is assured of receiving between 50 cents and 78 cents from the federal government. Connecticut's "matching rate" is 50 percent.

Why are Medicaid costs rising?

Growing Medicaid costs reflect increases in costs across the health care system, higher costs for the elderly and people with disabilities, and the program's role as a crucial safety net in times of economic downturn. Governor Rowland's proposed 2003–2005 budget notes increases in private sector health costs and identifies "Health care inflation in the state budget (is) the single source of the greatest increase in costs."¹² Nationwide, per person health care costs in Medicaid have actually been growing at a significantly lower rate than costs in the private sector. Private health insurance premiums rose by an average of 7.1 percent from 1997–2002, while Medicaid costs, after adjusting for increases in enrollment, grew by 4.76 percent over the same period of time¹³. In Connecticut, the growth in state employee health plan costs for FY 2004 is projected to be 25 percent, a much higher rate of growth than the 8.7 percent anticipated for Medicaid spending.¹⁴

Connecticut is one of a few states that responded to this budget crisis by reducing eligibility. The state recently adopted cuts in parent eligibility for its HUSKY program by lowering eligibility from 150

percent to 100 percent of poverty. This change is expected to result in the loss of health coverage for approximately 19,000 parents.¹⁵ In addition, the state has already undertaken a number of measures to reduce the cost of prescription drugs, cited in the Governor's budget as one of the main causes of increasing costs in the state's budget.¹⁶ The Governor has a number of additional proposals in this year's biennial budget, and a number of additional changes to Medicaid/SCHIP eligibility and benefits may be considered. Final action by the legislature is pending.

To respond to the severe fiscal pressures that many states are facing, Congress included a \$20 billion package of state aid in the recently enacted tax cut legislation. As a result, Connecticut will receive a temporary increase in its federal matching assistance percentage from 50 percent to 52.95 percent.

Under this provision, Connecticut can expect to receive \$132.6 million in additional Medicaid dollars for the period between April 2003 and June 2004. In addition, Connecticut will receive approximately \$116 million in state social services funding.¹⁷



“Health care inflation in the state budget (is) the single source of the greatest increase in costs.”¹²

According to the Governor's Budget

AN OVERVIEW OF THE PRESIDENT'S PROPOSAL

As part of its FY 2004 budget proposal, the Administration announced a sweeping proposal that would fundamentally restructure both the Medicaid and SCHIP programs. Under the proposal states would have two options:

- They could continue to run Medicaid and SCHIP under existing rules and receive the normal federal Medicaid and SCHIP federal matching payments.

OR

- States could choose to turn their Medicaid programs into a block grant and merge their federal Medicaid and SCHIP funds. States choosing this route would receive some upfront additional federal funding in exchange for agreeing to capped federal payments starting in FY 2004.

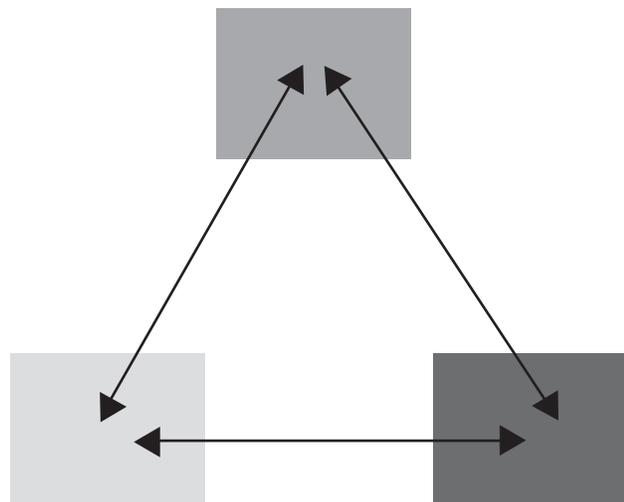
While details of the proposal are still evolving, the Administration's approach includes three key elements:

<p>Capped federal payments.</p> <p>The current system in which the federal government shares the full cost of Medicaid coverage would be replaced with a system in which states receive capped allotments (combining Medicaid and SCHIP funding) on a yearly basis. These payments would be based on FY 2002 spending, trended forward to account for some growth in costs. If costs grow at rates that are higher than those that are built into the ten-year block grant payments, states would receive no additional federal payments or only relatively minor adjustments based on certain pre-determined factors.</p> <p>1</p>	<p>An end to the federal matching payment system.</p> <p>The current system in which federal dollars are provided to states as a match on a state's investment of its own funds would be replaced by a "maintenance of effort" (MOE) requirement. States could receive their full federal allotment as long as they maintained a prescribed level of spending. The MOE requirement would be based on FY 2002 spending and grow at slower rates than state spending is projected to grow under current law. Because the two streams of funds (federal and state) would no longer be tied together and the MOE requirement would be set below the level of spending states are otherwise expected to spend, states could lower their Medicaid spending without losing federal dollars.</p> <p>2</p>	<p>Elimination or revision of many beneficiary standards and protections.</p> <p>In exchange for accepting caps on federal funding, states would be granted much broader programmatic flexibility than they have today. The Administration's proposal would drop virtually all federal Medicaid standards or protections for some beneficiaries under Medicaid and would substantially modify the standards and protections that would apply to most optional groups of beneficiaries. Some changes could be adopted even for "mandatory" groups of Medicaid beneficiaries.</p> <p>3</p>
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HOW WOULD CONNECTICUT FARE?

As described above, the President's proposal to restructure Medicaid would end open-ended federal matching payments to states that select the block grant option and allow states to reduce their state Medicaid spending. In exchange for capped federal funding, many of the federal standards regarding eligibility, benefits and cost sharing and other consumer protections would be eliminated or modified substantially. The new structure would offer states some new opportunities to improve coverage, but the financing changes would make it unlikely that states could take advantage of these opportunities and instead could push states to reduce coverage, consumer safeguards, and provider payments. This section of the report considers the risks posed by block grant financing in light of some of the factors unique to Connecticut that could exacerbate the problems that Connecticut might face under a block grant structure.

By eliminating open-ended federal matching payments, the block grant approach would shift the risk of higher costs onto states, local providers, and beneficiaries.



Capped federal payments would shift the risk of higher-than-projected costs onto the state. By eliminating open-ended federal matching payments, the block grant approach would shift the risk of higher costs onto states, local providers, and beneficiaries. Health coverage and long-term care costs are notoriously difficult to predict at either the state or the federal level. The Congressional Budget Office's 1998 projections of federal Medicaid spending for 2002 turned out to be off by 12 percent, a \$17 billion miscalculation.¹⁸ Ten-year projections are even more difficult to make with any degree of accuracy, yet the total amount of block grant funds that would be available for allocation to states between 2004 and 2013 would be determined based on projections developed in 2003. Some adjustments could be built into the annual block grant payments, but by definition, no pre-set formula distributing a finite amount of funds to states could accommodate each state's needs fully and in a timely and equitable way.

A myriad of factors influence the level of Medicaid spending, some of which cannot be tracked with accurate state-based data and some of which can only be recognized and documented well after the fact.¹⁹ Consider, for example, the impact that AIDS and HIV have had on Medicaid costs. Medicaid is the largest source of funding for AIDS health care services in the United States. In 1983, however, only 28 new number AIDS cases were reported in Connecticut. By 1993, the number had risen to 1,700.²⁰ Few predicted that jump or the expense that would be incurred by Medicaid programs as a result of AIDS and HIV. Unforeseeable costs, such as those that flow from the outbreaks of new diseases like Severe Acute Respiratory Syndrome (SARS), the consequences of bioterrorism, or new breakthroughs in medical technology cannot be accommodated under a block grant structure.

Under current law, a state facing higher than anticipated health care costs may choose to curtail program coverage or it may pay those higher costs in partnership with the federal government. In recent years, Connecticut has chosen to do both — it assumed some higher costs in Medicaid, sharing half those costs with the federal government, and it reduced coverage and benefits. Had a block grant been in place, Connecticut would not have had the option of sharing any of the higher costs with the federal government if it had already been spending its capped allotment.

Capped federal funding eliminates perhaps the most fundamental aspect of the flexibility granted to states under the Medicaid program — the flexibility of having federal funding levels respond automatically and fully to state costs.

Connecticut would have a higher-than-average share of its spending subject to capped federal payments.

The risks posed by capped federal funding could be particularly large for Connecticut because a larger-than-average share of Connecticut's spending would be subject to the capped federal payments. As noted above, the President's proposal would place all optional spending under capped allotments for states choosing the block grant option. The more funding that is under a cap, the greater the financial risk that is borne by the state. For the nation as a whole, about 65 percent of all Medicaid spending is optional, meaning that the average state would assume the risk of higher-than-projected costs with respect to about two-thirds of its spending.²¹ Each state is unique, however, in terms of how much it spends on mandatory versus optional populations and services. Since states do not divide their programs or report their spending based on these distinctions, it is difficult to know exactly what the split would be for Connecticut, but it appears that a substantially higher share of Connecticut's costs would fall within the capped allotments.

This is in part due to the choices Connecticut has made to adopt many federal options, but it is largely due to the cost of serving elderly people in nursing homes throughout the state. Connecticut covers a relatively high portion of its elderly residents under Medicaid; and, as noted above, most of the elderly people covered under Medicaid are optional beneficiaries. These optional elderly individuals accounted for

40.6 percent of all Medicaid spending in the state, compared to 20.3 percent for the U.S. average. Connecticut's costs for optional people with disabilities are similarly large relative to the nation as a whole. These individuals accounted for 25.6 percent of all Medicaid spending in the state, compared to 13.9 percent for the U.S. average.²² If a block grant were implemented in Connecticut along the lines of the President's proposal, the state would be giving up its open-ended federal Medicaid payments for these costs and assuming the risk of higher-than-projected costs on a larger share of its spending than many other states.

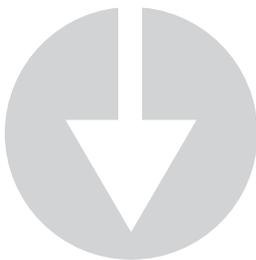
The risks posed to Connecticut would be significant particularly in light of the growth in the cost of serving the elderly and people with disabilities and the aging population.

Connecticut's block grant payment would likely grow at a relatively slow rate under the President's proposal.

The Administration's proposal would set each state's capped federal payment based on the amount of federal payments (in Medicaid and SCHIP) that the state received in 2002. Since Connecticut's spending per beneficiary, particularly for the elderly, is higher than average, its base payment would reflect those higher-than-average costs. The state's annual block grant payment, however, would likely grow at a lower-than-average rate, increasing the risk that Connecticut could face a federal funding shortfall over the course of the ten-year block grant period.

Under the Administration's approach, the total amount of federal funds that would be distributed to states would grow each year according to CBO's ten-year projections of federal Medicaid spending growth (the

average annual growth rate is 9.39 percent), but the funds would then be allocated to states based on each state's historical growth rate. This approach was chosen to avoid a one-size-fits-all growth rate for state allotments, but it could be particularly problematic for states like Connecticut that have had low growth rates in recent years. Between 1998 and 2001, Connecticut's overall Medicaid expenditures grew more slowly than almost every other state, ranking 49 out of 51 states (including the District of Columbia). Its average annual growth rate during this period was 5.26 percent compared to 8.76 percent for the nation. Looking at a longer period, between 1993 and 2001, Connecticut still ranked close to the bottom; 45 out of the 51 states (including D.C.).²³



The state's annual block grant payment, however, would likely grow at a lower-than-average rate, increasing the risk that Connecticut could face a federal funding shortfall over the course of the ten-year block grant period.

Table 1

Medicaid Expenditures, Average Annual Growth Rates

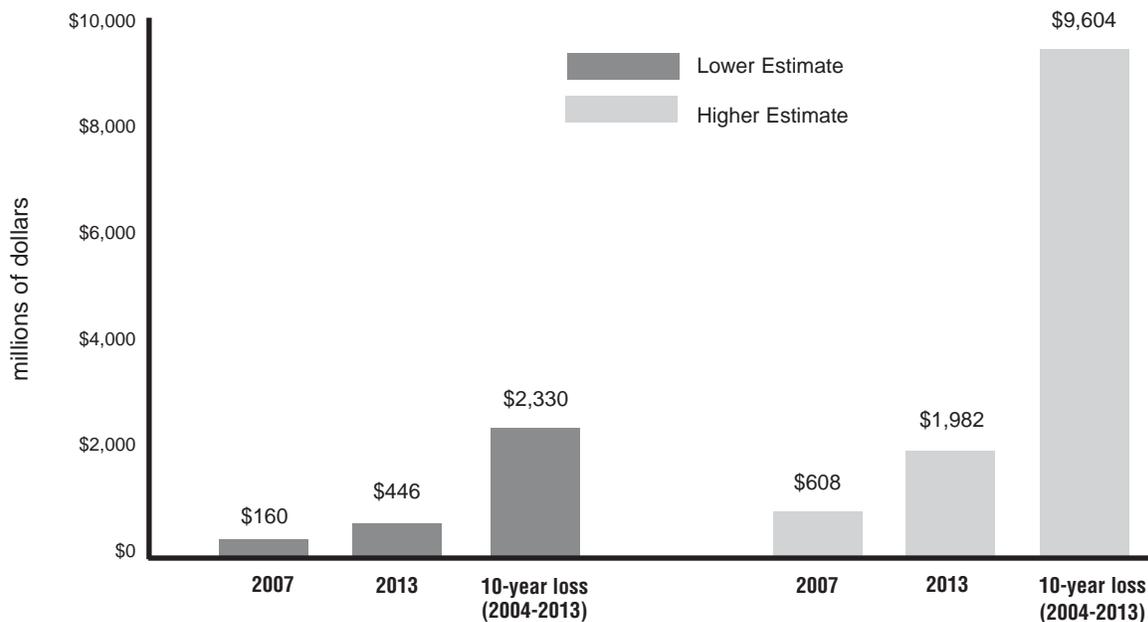
	1993-1997	1998-2001	1992-2001		1993-1997	1998-2001	1992-2001
Alabama	7.7 percent	7.41 percent	7.5 percent	New Hampshire	-1.3 percent	4.56 percent	2.2 percent
Alaska	9.0 percent	16.23 percent	12.5 percent	New Jersey	3.9 percent	9.70 percent	6.2 percent
Arizona	6.3 percent	12.43 percent	9.8 percent	New Mexico	13.4 percent	11.81 percent	12.1 percent
Arkansas	6.2 percent	9.07 percent	7.8 percent	New York	5.3 percent	5.40 percent	6.4 percent
California	5.0 percent	9.74 percent	8.2 percent	North Carolina	11.8 percent	10.00 percent	10.8 percent
Colorado	5.0 percent	10.63 percent	7.0 percent	North Dakota	5.3 percent	6.98 percent	5.8 percent
Connecticut	6.6 percent	5.36 percent	5.4 percent	Ohio	5.6 percent	8.02 percent	6.5 percent
Delaware	12.8 percent	12.02 percent	11.9 percent	Oklahoma	2.4 percent	15.32 percent	7.8 percent
District of Columbia	3.8 percent	9.52 percent	5.5 percent	Oregon	12.7 percent	15.57 percent	14.2 percent
Florida	6.8 percent	9.48 percent	8.6 percent	Pennsylvania	9.5 percent	8.51 percent	6.8 percent
Georgia	6.4 percent	12.94 percent	8.5 percent	Rhode Island	2.6 percent	7.88 percent	5.1 percent
Hawaii	13.4 percent	2.18 percent	8.1 percent	South Carolina	6.3 percent	10.10 percent	8.0 percent
Idaho	9.6 percent	16.31 percent	11.4 percent	South Dakota	5.6 percent	9.45 percent	7.9 percent
Illinois	6.9 percent	6.82 percent	7.3 percent	Tennessee	6.4 percent	13.25 percent	9.4 percent
Indiana	-3.2 percent	16.03 percent	5.6 percent	Texas	7.8 percent	5.71 percent	7.0 percent
Iowa	6.3 percent	6.08 percent	7.5 percent	Utah	7.2 percent	7.14 percent	8.0 percent
Kansas	3.7 percent	16.20 percent	8.6 percent	Vermont	9.6 percent	14.63 percent	10.6 percent
Kentucky	8.4 percent	9.02 percent	7.1 percent	Virginia	6.1 percent	9.97 percent	7.9 percent
Louisiana	-4.9 percent	11.03 percent	3.1 percent	Washington	8.4 percent	9.49 percent	9.0 percent
Maine	6.2 percent	6.66 percent	6.8 percent	West Virginia	-0.1 percent	6.93 percent	5.6 percent
Maryland	8.4 percent	7.47 percent	6.4 percent	Wisconsin	5.0 percent	8.85 percent	6.4 percent
Massachusetts	5.9 percent	6.27 percent	4.9 percent	Wyoming	9.6 percent	7.01 percent	8.3 percent
Michigan	6.3 percent	8.25 percent	7.4 percent				
Minnesota	6.1 percent	9.98 percent	8.1 percent	U.S.	5.9 percent	8.76 percent	7.3 percent
Mississippi	9.2 percent	14.03 percent	9.8 percent				
Missouri	8.7 percent	12.18 percent	8.0 percent	Note:	Medicaid expenditures include expenditures for benefits and Disproportionate Share Hospital payments.		
Montana	4.9 percent	7.91 percent	7.3 percent				
Nebraska	6.7 percent	12.70 percent	10.8 percent	Source:	Urban Institute estimates based on data from HCFA-64 reports. Does not include administrative costs, accounting adjustments, or the U.S. Territories.		
Nevada	3.7 percent	9.32 percent	7.1 percent				

While historical growth rates may be the only objective way to set state-specific growth rates, they are not necessarily good indicators of future Medicaid funding needs. States show very uneven patterns of expenditure growth. Table 2 (page 16) ranks states based on their expenditure growth rates during 1993 – 1997 and 1998 – 2001. A comparison of the two periods shows that only two of the ten states with the lowest growth rate in the first period (West Virginia and New Hampshire) were among the ten states with the lowest growth rates in the second period. Three of the states with the lowest growth rates in the first period (Kansas, Oklahoma, and Indiana) were among the ten states whose expenditures grew most rapidly during the second period. If Connecticut’s below-average historical growth rates are built into the capped payment levels the state would receive over the next ten years, Connecticut will have an even more difficult time managing its costs and providing for its residents’ needs under a block grant.

The block grant would change the fiscal incentives that encourage Connecticut to maintain investments in coverage. Under the President’s proposal, a state could reduce its state spending without losing any of its capped federal payments as long as it met the new maintenance of effort (MOE) requirement. The opportunity to withdraw state funds has been touted by the Administration as one of the features of the block grant proposal that should be most appealing to governors. In fact, states may not be able to pull out all of the state funds that the new approach would permit them to withdraw because states may need to increase state funding to make up for federal funding shortfalls. Nonetheless, the potential for reduced state spending is significant. The MOE provision could result in the loss of \$2.3 billion to \$9.6 billion in Connecticut’s funding for Medicaid services over the next ten years, compared to the amount of state funds that might otherwise be invested in Medicaid under current law.²⁴

Figure 4

Potential Loss of State Spending Under Maintenance of Effort (MOE)



Note: Lower estimate shows the difference between MOE and state spending projections under current law assuming program expenditures grow at 5.38 percent (CT’s Medicaid expenditure growth rate from 1998 - 2001). Higher estimate shows the difference between MOE and state spending projections under current law assuming program expenditures grow at 9.39 percent (CBO 2003 Medicaid baseline growth rate for the years 2004-2013). MOE growth is based on 2002 state expenditures adjusted by the Medical CPI projected by HHS.

Table 2

Medicaid Expenditures, Average Annual Growth

Growth 1993-1997			Growth 1998-2001		
1	New Mexico	13.43 percent	1	Idaho	16.31 percent
2	Hawaii	13.37 percent	2	Alaska	16.23 percent
3	Delaware	12.77 percent	3	Kansas	16.20 percent
4	Oregon	12.74 percent	4	Indiana	16.03 percent
5	North Carolina	11.83 percent	5	Oregon	15.57 percent
6	Vermont	9.59 percent	6	Oklahoma	15.32 percent
7	Idaho	9.57 percent	7	Vermont	14.63 percent
8	Wyoming	9.57 percent	8	Mississippi	14.03 percent
9	Pennsylvania	9.52 percent	9	Tennessee	13.25 percent
10	Mississippi	9.21 percent	10	Georgia	12.94 percent
11	Alaska	8.98 percent	11	Nebraska	12.70 percent
12	Missouri	8.69 percent	12	Arizona	12.43 percent
13	Maryland	8.40 percent	13	Missouri	12.18 percent
14	Washington	8.39 percent	14	Delaware	12.02 percent
15	Kentucky	8.38 percent	15	New Mexico	11.81 percent
16	Texas	7.76 percent	16	Louisiana	11.03 percent
17	Alabama	7.68 percent	17	Colorado	10.63 percent
18	Utah	7.20 percent	18	South Carolina	10.10 percent
19	Illinois	6.89 percent	19	North Carolina	10.00 percent
20	Florida	6.84 percent	20	Minnesota	9.98 percent
21	Nebraska	6.71 percent	21	Virginia	9.97 percent
22	Connecticut	6.55 percent	22	California	9.74 percent
23	Tennessee	6.45 percent	23	New Jersey	9.70 percent
24	Georgia	6.38 percent	24	District of Columbia	9.52 percent
25	South Carolina	6.35 percent	25	Washington	9.49 percent
26	Iowa	6.34 percent	26	Florida	9.48 percent
27	Arizona	6.26 percent	27	South Dakota	9.45 percent
28	Michigan	6.25 percent	28	Nevada	9.32 percent
29	Maine	6.24 percent	29	Arkansas	9.07 percent
30	Arkansas	6.24 percent	30	Kentucky	9.02 percent
31	Virginia	6.15 percent	31	Wisconsin	8.85 percent
32	Minnesota	6.11 percent	32	Pennsylvania	8.51 percent
33	Massachusetts	5.92 percent	33	Michigan	8.25 percent
34	South Dakota	5.64 percent	34	Ohio	8.02 percent
35	Ohio	5.61 percent	35	Montana	7.91 percent
36	North Dakota	5.33 percent	36	Rhode Island	7.88 percent
37	New York	5.26 percent	37	Maryland	7.47 percent
38	Wisconsin	5.03 percent	38	Alabama	7.41 percent
39	California	5.02 percent	39	Utah	7.14 percent
40	Colorado	5.02 percent	40	Wyoming	7.01 percent
41	Montana	4.94 percent	41	North Dakota	6.98 percent
42	New Jersey	3.87 percent	42	West Virginia	6.93 percent
43	District of Columbia	3.76 percent	43	Illinois	6.82 percent
44	Kansas	3.70 percent	44	Maine	6.66 percent
45	Nevada	3.68 percent	45	Massachusetts	6.27 percent
46	Rhode Island	2.57 percent	46	Iowa	6.08 percent
47	Oklahoma	2.35 percent	47	Texas	5.71 percent
48	West Virginia	-0.13 percent	48	New York	5.40 percent
49	New Hampshire	-1.33 percent	49	Connecticut	5.36 percent
50	Indiana	-3.20 percent	50	New Hampshire	4.56 percent
51	Louisiana	-4.87 percent	51	Hawaii	2.18 percent
	U.S.	5.94 percent		U.S.	8.76 percent

Figure 5

Matching System Creates Incentives to Maintain State Investment in Optional Coverage

CURRENT LAW				PROPOSAL		
Federal dollars lost if CT reduces Medicaid spending by \$125 million, at Medicaid and SCHIP match rates				Federal dollars lost if CT reduces Medicaid spending by \$125 million (assuming state meets MOE)		
Match Rate	State Funds Withdrawn (millions)	Federal Dollars Lost (millions)	Total Reductions (millions)	State Funds Withdrawn (millions)	Federal Dollars Lost (millions)	Total Reductions (millions)
50%	\$125	\$125	\$250	\$125	\$0	\$125
65%	\$125	\$232	\$357			

The substitution of an MOE requirement for the current matching system eliminates a key incentive for states to maintain their investment in the program. Figure 5 compares what would happen if Connecticut sought to withdraw \$125 million in state funds under the current system and under the block grant structure. Under the existing financing rules, if Connecticut cuts state spending by \$125 million, it loses \$125 million in federal Medicaid funds (it would lose \$232 million under the 65 percent SCHIP matching rate). By con-

trast, under the President’s approach, the state could pull out these dollars and not lose any federal funds, as long as the state met its MOE requirement. The Medicaid program works largely through options and fiscal incentives. Under the existing structure, the potential loss of federal funds discourages — but does not prevent — states from cutting back on optional spending. If the incentives were to change, state-funding behavior can be expected to change as well.

Connecticut would not receive additional federal funds (above the capped payment) for improvements and expansions.

As the economy improves, Connecticut might consider restoring some of the cutbacks it recently adopted or other ways to improve the coverage it offers to its residents. The block grant financing system, however, would make it difficult for Connecticut to take such steps. For example, if the state found that the loss of continuous eligibility periods for children impaired the state’s ability to ensure that children received regular primary and preventive care, including immunizations, and wanted to reintroduce 12-month eligibility periods for children sometime in the future, the state would not receive any additional funds from the federal government to share the additional cost of this improvement. Similarly, if the state sought to restore coverage for low-income working parents, that cost too would have to be borne solely by the state or offset by cuts in spending for other beneficiaries.

Figure 6 compares the financing consequences under current law versus a block grant of a state’s decision to invest new state dollars to improve the program. Under current law, if Connecticut is considering a program improvement that would cost \$250 million, that improvement would cost the state \$125 million in state funds (less if the spending is through SCHIP) and the investment brings \$125 million in new federal funds into the state. Under the block grant, the state would have to shoulder all of the cost of a \$250 million program improvement, assuming it was already spending its full federal allotment. In addition, no new federal funds are leveraged through the state’s investment. The change in the financing rules would remove the fiscal incentives that encourage states to invest funds to improve their programs and make it at least twice as expensive for a state to make improvements.

Figure 6

Matching System Creates Incentives for State to Invest in Optional Coverage

CURRENT LAW				PROPOSAL		
Value of improvement and federal dollars gained if CT invests \$125 million, at Medicaid and SCHIP match rates				Value of improvement and federal dollars gained if CT invests \$125 million (assuming the state is receiving its full federal allotment)		
Match Rate	New State Investment (millions)	Additional Federal Funds (millions)	Total Value of Improvement (millions)	New State Improvement (millions)	Additional Federal Funds (millions)	Total Value of Improvement (millions)
50%	\$125	\$125	\$250	\$125	\$0	\$125
65%	\$125	\$232	\$357			

Connecticut's Medicaid costs — particularly for the elderly — are much higher than costs in most other states.

Block grants create a zero sum game. Unless a state is willing and able to shoulder new costs on its own, funding shortfalls and improvements in the program will need to be addressed by making reductions in the cost of serving those who are already covered by the program. Competition for limited funds is not new. State resources are not unlimited, and, therefore, different population groups and their providers are often, in effect, competing for available funds. Block grants, however, exacerbate the competition, by adding funding caps to the federal side of the equation.

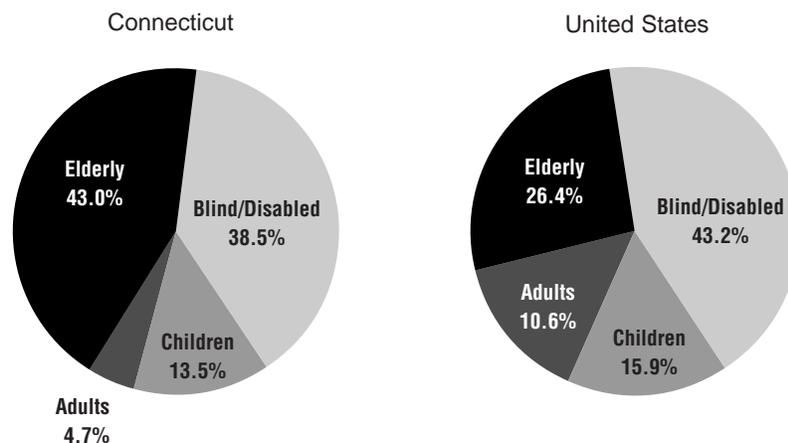
How might that competition be addressed in Connecticut? The answer to this question is beyond the scope of this paper, but it is important to recognize how Connecticut's current distribution of spending within the Medicaid program could affect the choices it will have to achieve savings under a block grant. Nationwide, states typically spend a far greater share of their Medicaid funds on services for the elderly and people with disabilities because of their relatively high need for medical care. The distribution in spending across groups is even more skewed in Connecticut for several reasons. Connecticut has a modestly larger elderly population than the nation as a whole (in 2002,

14.2 percent of its population was 65 years of age or older, compared to 12 percent for the nation²⁵). Most significantly, the cost of caring for the elderly is considerably higher in Connecticut than in most other states. Connecticut's spending per elderly beneficiary is close to the cost in New York, but well above the national average — \$21,980 in Connecticut compared to \$10,362 for the nation.²⁶

As noted above, 43 percent of all of Connecticut's Medicaid spending is for the elderly and almost 39 percent is for the care provided to people with disabilities, accounting for over 80 percent of all Medicaid expenditures in the state. Children account for less than 14 percent of spending and parents and pregnant women less than 5 percent, even though they account for a much larger share of the number of people served under the program. Given this distribution of spending, if significant savings are to be achieved within the context of block grant funding, either major changes will need to be made in the number of elderly people and people with disabilities being served or in the cost of serving them, or spending for children, parents and pregnant women will need to be cut deeply (in addition to the reductions that have already occurred).

Figure 7

Share of Medicaid Spending on the Elderly is Higher in CT than the US (2000)



Source: Georgetown University Health Policy Institute analysis based on Centers for Medicare and Medicaid Services MSIS 2000 data.

OTHER APPROACHES

States from every area of the country are grappling with ways to manage their health care coverage and long-term care costs in the face of shrinking state revenues, rising health care costs, growing Medicaid enrollment due to the economic downturn, and an aging population. Solutions to these problems are needed and could take many forms, including the following:

Having the federal government pick up the cost of providing drug coverage to low-income Medicare beneficiaries.

As noted above, state Medicaid programs are currently responsible for the cost of providing prescription drugs to low-income seniors and people with disabilities who qualify for Medicare and Medicaid (the so-called “dual eligibles”). This is a large and growing cost for states, and much of states’ fiscal problems could be alleviated if they were no longer responsible for these costs. An analysis by the Commonwealth Fund

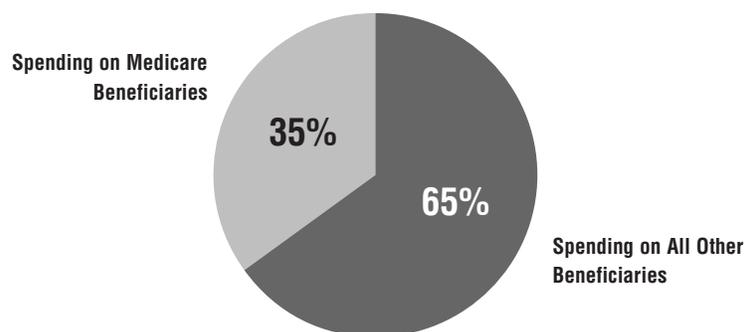
shows that Connecticut spent close to \$137 million on prescription drug coverage for dual eligibles in 2002.²⁷ Currently, Congress is debating a Medicare prescription drug bill that may — or may not — shift the cost of the drugs provided to low-income Medicare beneficiaries from state Medicaid programs to the federally-financed Medicare program.

Figure 8

Medicaid Fills Medicare’s Gaps

Over One-Third of Medicaid Benefit Spending – \$68 billion — is for Services for Medicare Beneficiaries

This Grows Over Time with the Baby Boomers’ Retirement



Source: Secretary's Advisory Committee on Regulatory Reforms, June 2002. Data for 1999.

Shifting costs for “dual eligibles” from Medicaid to Medicare.

State Medicaid programs also shoulder the cost of other services for Medicare beneficiaries that are not covered by Medicare, most notably long-term care. The federal government could take a number of steps to alleviate some of these costs. Most directly, it could pick up these costs under Medicare (quite an expensive undertaking for the federal government), or it could take a more modest step to provide states with a higher

matching rate in Medicaid for some or all of these services. The federal government could also help states manage their dual eligible costs by giving states greater flexibility to manage the care of dual eligible individuals and allowing states that take steps to improve care (e.g., through disease management programs) to realize some of the savings that now accrue largely to the federal Medicare program (e.g., through reduced hospitalizations).

Providing for automatic increases in the federal Medicaid matching rate during economic downturns.

Recently, the federal government adopted a temporary adjustment in the federal Medicaid matching rate to address the higher Medicaid enrollment states experience during a downturn when more people lose their jobs and their employer-based insurance. This kind of adjust-

ment could be built into the Medicaid program so that the federal matching rate automatically rose during a downturn. A bill cosponsored by Senator Bingaman (D-NM) and Congressman Dingell (D-MI) calls for this type of fiscal relief.

Expanding state flexibility in certain areas.

It is possible to consider flexibility proposals outside of the context of capped federal financing. In 1997, for example, federal law was revised to give states broad authority to require most beneficiaries to enroll in managed care and to set provider payment rates for nursing homes and hospitals.

Changes in some of the current federal standards and options could be considered without linking those changes to capped federal financing. At the same time, it is important to consider the value of retaining national standards in key areas.

Increasing the Medicaid drug rebate and other measures to reduce prescription drug costs.

Under current law, the price a state Medicaid program pays for prescription drugs is net of a rebate established by federal law. Drug manufacturers must pay this rebate amount as a condition of receiving Medicaid payments for outpatient drugs, but the rebate level has not been adjusted since it was first set in 1990. Some states have attempted to require drug companies doing business in their state to provide a supplemental rebate but these arrangements have been contentious for many reasons. An adjustment to the national rebate would benefit all states and has been

endorsed by the President and by the NGA. Other approaches to bringing down drug costs include drug-pricing disclosures that could help inform states about whether the prices they are paying for drugs in their Medicaid programs are appropriate given the local market. Changes outside of the Medicaid program, such as proposals to limit direct-to-consumer advertising and to promote the availability of generic drugs could help bring public and private sector health costs down.

Encouraging more long-term care services in the community.

There are many reasons for addressing the need for more community-based, long-term care services, other than costs but cost savings are sometimes identified as a reason for shifting more long-term care into the community. Federal legislation sponsored by Senator Harkin (D-IA) would make home- and community-based services a state option (rather than a waiver service as it is now under federal Medicaid law). If enacted, the bill would greatly expand the

availability of community-based services, but the option would carry new costs because it would be available to a broader group of people than states have been covering through waivers. Additional approaches to expanding community-based, long-term care services have been suggested; for example, by making it easier for states to obtain and renew home- and community-based service waivers.

In addition to these approaches that can help address cost-related issues, even in these difficult times, some states are looking for ways to use Medicaid to cover more of the uninsured. Options that would let states cover childless adults without having to seek a “budget neutral” waiver as well as approaches that could make coverage expansions less costly to states (e.g., by extending an enhanced federal matching payment to states that cover new populations) should be part of the mix of Medicaid restructuring measures if continued progress covering the uninsured is to be made. With 41 million uninsured people in this country and rapidly rising health care costs in both the private and public sectors threatening to push that number much higher, approaches are needed that move us forward, not backward, toward the goal of assuring that all people have access to health care.

CONCLUSION

Connecticut's Medicaid program provides critical coverage and long-term care services to hundreds of thousands of its residents, but rising costs and declining revenues have created challenges for Connecticut and other states. Connecticut's relatively high expenditures for long-term care and its growing elderly population create major challenges for the state and its ability to serve all of its residents even under the current Medicaid financing structure. State Medicaid programs are the single largest source of funds for long-term care, and the demand for long-term care — nursing home care as well as community-based care — is growing. Solutions are needed to address these cost pressures; some of those solutions might involve providing states more flexibility to design program services and benefits and some might involve changes to Medicare and the broader health care marketplace. The question for Connecticut and other states is whether a cap on federal Medicaid financing, coupled with new programmatic flexibility, will move states closer to or farther from finding constructive solutions to address the growing demand for and cost of coverage and long-term care services.

Medicaid “Mandatory” and “Optional” Eligible Groups

“MANDATORY” GROUPS	“OPTIONAL” GROUPS
<ul style="list-style-type: none"> • Children under age 6 \leq 133% Federal Poverty Line (FPL) • Children age 6 and older \leq 100% FPL • Children in foster care • Pregnant women \leq 133% FPL • Parents with incomes below state-established minimums (median = 60% FPL) • Elderly and disabled SSI beneficiaries (incomes \leq 74% FPL) • Low-income Medicare beneficiaries 	<ul style="list-style-type: none"> • Children and parents above minimum requirements • Pregnant women $>$ 133% FPL • Disabled and elderly people $>$ 74% FPL, including those in nursing homes • Disabled and elderly people served under Home and Community Based waivers • Women with breast and cervical cancer • Certain disabled people who are employed and buy into coverage

Source: Kaiser Commission on Medicaid and the Uninsured, “The Medicaid Resource Book,” July 2002

Medicaid Statutory Services

MANDATORY SERVICES		OPTIONAL SERVICES	
Acute Care			
<ul style="list-style-type: none"> • Physician, nurse practitioner and nurse midwife services • Laboratory and x-ray services • Inpatient and outpatient hospital services 	<ul style="list-style-type: none"> • Screening and treatment services for children (EPSDT) • Family planning services • Federally-qualified health center (FQHC) and rural health clinic (RHC) services 	<ul style="list-style-type: none"> • Prescribed drugs • Medical care or remedial care furnished by licensed practitioners under state law • Diagnostic, screening, preventive, and rehabilitative services • Clinic services • Dental services, dentures 	<ul style="list-style-type: none"> • Physical therapy and related services • Prosthetic devices • Eyeglasses • TB-related services • Primary care case management services • Other specified medical and remedial care
Long-term Care			
<ul style="list-style-type: none"> • Nursing facility services for people 21 years of age or older 	<ul style="list-style-type: none"> • Home health care services (for people entitled to nursing facility care) 	<ul style="list-style-type: none"> • Intermediate care facility for people with mental retardation (ICF/MR) services • Inpatient and nursing facility services for people 65 or over in an institution for mental diseases (IMD) • Inpatient psychiatric hospital services for children • Home health care services • Case management services 	<ul style="list-style-type: none"> • Respiratory care services for ventilator-dependent individuals • Personal care services • Private duty nursing services • Hospice care • Services furnished under a "PACE" program • Home and community-based (HCBS) services (under budget neutrality waiver)

Source: Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book," July 2002

Comparison of CT Medicaid to Federal Employee Health Benefits Program

	CT Medicaid¹	FEHBP
Prescription (inpatient and outpatient)	Yes	Yes
Care furnished by state-licensed chiropractors, psychologists, and psychologists	Yes	Yes ²
Diagnostic, screening, and preventive services	Yes	Yes
Rehabilitative services	Yes ³	Yes
Clinic services	Yes	Yes
Dental services and dentures	Yes	Yes ⁴
Physical therapy and related services	Yes ⁵	Yes ⁶
Prosthetic devices, including eyeglasses	Yes	Yes ⁷
Inpatient hospital services for mental health/inpatient psychiatric hospital care	Yes	Yes
Intermediate care facility for individuals with mental retardation (ICF/MR) services	Yes	No
Home- and community-based services (HCBS) (under waiver authority)	Yes	No
Case management services	Yes ⁸	No
Personal care services	No	No
Hospice care	No	Yes

¹ Some type of service limit applies to nearly all Medicaid categories in CT.

² Does not cover chiropractor services or routine foot care.

³ Mental Health Rehabilitation and Stabilization not covered.

⁴ Plan does not cover dentures, orthodontia, or services for periodontal disease.

⁵ Occupational therapy not covered.

⁶ Physical therapy limited to 50 visits/year; occupational and speech therapy (combined) limited to 25 visits/year.

⁷ Eyeglasses provided only following intra-ocular surgery or injury; hearing aids not covered.

⁸ Primary Care Case Management not covered.

Note: FEHBP benefits based on Blue Cross/Blue Shield Standard PPO under FEHBP for 2001. State benefits based on CT BC/BS State Preferred PPO.

Sources: Schneider A, et. al. *The Medicaid Resource Book*. Kaiser Commission on Medicaid and the Uninsured, July 2002; Medicaid At-a-Glance 2002. Centers for Medicare and Medicaid Services, November 2002.

- ¹ *Introduction to Governor's Budget Summary, Connecticut 2003-2005 Biennial Budget*, p. b-102. Available online at www.opm.state.ct.us/budget.
- ² V. Smith, K. Gifford, R. Ramesh and V. Wachino, *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003*, Kaiser Commission on Medicaid and the Uninsured, January 2003.
- ³ Employer premiums rose on average 12.8 percent in 2002. *Employer Health Benefits: Annual Survey 2002*, Kaiser Family Foundation/Health Resource Educational Trust. Estimates of Medicaid per capita costs and expenditure growth based on Congressional Budget Office (CBO) March 2003 baseline.
- ⁴ Estimate based on Connecticut's CMS Form 37.
- ⁵ "Medicaid Today: The States' Perspective" Hearing of the House Energy and Commerce Committee, March 13, 2003. Available online from the Kaisernetwork at: http://www.kaisernetwork.org/health_cast/uploaded_files/kff03120_3_eandc_medicaid.pdf.
- ⁶ Other members of the Task Force included Republicans Kempthorne (ID), Ehrlich (MD), J. Bush (FL), and Hoeven (ND); and Democrats Patton (KY), Holden (MO), Richardson (NM), O'Bannon (IN), and Vilsack (IA).
- ⁷ On June 12, 2003, Governor Rowland and the other four Republican Governors on the Task Force sent a letter to Department of Health and Human Services (HHS) Secretary Tommy Thompson with an outline of a restructuring proposal that shared many of the fundamental features of the Administration's plan — including a cap on optional spending. The Democratic Governors issued their own statement with an outline of reforms they believe are necessary but issued a strong dissent on the idea of imposing a cap on federal funding.
- ⁸ CBO March 2003 baseline.
- ⁹ Connecticut Department of Social Services *Active Medical Assistance Coverage Groups Eligibility Report for April 2003*. Total enrollment for federally funded-Medicaid was 398,004; the number of children and parents enrolled in Husky A as of April was 297,303.
- ¹⁰ Health Policy Institute analysis based on CMS MSIS 2000 data.
- ¹¹ Health Policy Institute analysis based on CMS MSIS 2001 data.
- ¹² *Introduction to Governor's Budget Summary*, p. 79.
- ¹³ CBO March 2003 baseline estimates of Medicaid costs.
- ¹⁴ *Introduction to Governor's Budget Summary*, p. 7.
- ¹⁵ H. Waldman. *Low Income, But Not Low Enough*. Hartford Courant, June 16, 2003, p. 1.
- ¹⁶ *Introduction to Governor's Budget Summary*, p. 86.
- ¹⁷ Preliminary estimates on funding from the Center on Budget and Policy Priorities. Matching rate information from Ku, L. *State Fiscal Relief Provides an Opportunity to Safeguard Medicaid Budgets*, Center on Budget and Policy Priorities, June 4, 2003.
- ¹⁸ CBO baselines, March 1998 and March 2003. A report recently issued by the U.S. Department of Labor and the U.S. HHS projects that the total number of people in the country needing long-term care will rise from 13 million in 2000 to 27 million in 2050, but notes that there is a great deal of uncertainty in making these projections. *The Future Supply of Long-Term Care Workers in Relation To the Aging Baby Boom Generation*, Report to Congress, May 14, 2003, pages 8-9.
- ¹⁹ The draft plan considered by the Republican Governors in the NGA Task Force, including Governor Rowland, suggests that states be provided some adjustments to the capped federal payments based on specified unforeseen events. Adjustments could have only a limited impact, however, for the reasons noted above and, perhaps most significantly, because the adjustments themselves would need to be capped. Under the Congressional budget resolution adopted earlier this year, any Medicaid reform proposal would need to be "budget neutral" for the federal government. This means that the basic allotments and the adjustments to those allotments would need to fit within fixed, capped federal funding. The kind of open-ended adjustments contemplated by the Republican governors' draft could not be accommodated under federal budget rules. For a discussion of the limitations of such adjustments, see E. Park, C. Mann, J. Alker, M. Nathanson, *NGA Medicaid Task Force's Draft Proposal Shifts Fiscal Risks To States And Jeopardizes Health Coverage For Millions; Draft Offers Little Improvement over Flawed Administration Approach*, Georgetown University Health Policy Institute and Center on Budget and Policy Priorities, June 2003.
- ²⁰ Centers for Disease Control, HIV/AIDS Annual Surveillance Reports, 1983-1993.
- ²¹ The actual mechanism for assuring that states continue to be fully protected with respect to costs associated with providing mandatory benefits to mandatory beneficiaries has not been described with any specificity by the Administration; this analysis assumes that states would be fully protected for those costs but confirmation of this will await more detail.
- ²² This estimate is based on state MSIS data reported to the federal government and assumes that the elderly and disabled individuals who are reported as receiving cash assistance are mandatory beneficiaries. In general, elderly persons and people with disabilities who qualify for cash assistance under the federal Supplemental Security Income (SSI) program are mandatory beneficiaries under federal Medicaid law. Some states, like Connecticut, were grandfathered into a different but closely related standard for determining which elderly and disabled people in the state are mandatory.
- ²³ These calculations are based on Urban Institute analysis of data from HCFA-64 reports and include expenditures for benefits and Disproportionate Share Hospitals payments (DSH payments would be included in the block grant base payments). Growth rates for years prior to 1993 were not considered here because federal spending growth during the early 1990s was influenced heavily in some states by DSH financing arrangements that were subsequently prohibited by Congress.
- ²⁴ These figures are based on a calculation of the MOE requirement in Connecticut, adjusting Connecticut's 2002 state spending according to the U.S. Department of Health and Human Services' projections of Medical Consumer Price Index, compared to projected state spending under current law. The low estimate is based on a projection of state spending under current law mirroring Connecticut's historical spending growth in Medicaid between 1998 and 2001. The higher estimate assumes that state spending under current law would grow at the same rate as CBO projects for federal Medicaid spending nationwide. Further reductions in state contributions to the program could occur if the MOE requirement allowed states to count non-Medicaid health spending as meeting its MOE requirement. The issue of supplantation of state funding under state MOE requirements has been an issue in some states' Temporary Assistance to Needy Families (TANF) programs.
- ²⁵ Population data is from the March 2003 Current Population Survey.
- ²⁶ Per beneficiary spending data are from CMS MSIS data reports for 2000. Per person spending in New York for the elderly was \$19,522 in 2000.
- ²⁷ S. Dale and J. Verdier, Mathematica Policy Research, Inc., *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles*, Commonwealth Fund, April 2003.

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Cindy Mann is a Research Professor at Georgetown University's Health Policy Institute, analyzing health coverage, financing, and access issues affecting low-income populations. Immediately prior to joining the Georgetown faculty, Mann was the Director of the Family and Children's Health Program Group for the Center for Medicaid and State Operations at the Health Care Financing Administration (HCFA, now the Centers for Medicaid and Medicare Services). The New York University Law School alumna also worked at the Kaiser Commission on Medicaid and the Uninsured and at the Center on Budget and Policy Priorities after working on the state level in Massachusetts, Rhode Island and New York.

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Transcript from Report Presentation, June 20, 2003, Room 2C in the Legislative Office Building, Hartford

Judith Solomon, Executive Director of the Children's Health Council

Good morning, I'm Judith Solomon, Executive Director of the Children's Health Council. It is my pleasure this morning to welcome you here on behalf of the Anthem Foundation of Connecticut, the Connecticut Health Foundation and the Children's Health Council. We extend our thanks to Representative Jack Thompson for hosting us here at the LOB (Legislative Office Building) and he will be joining us later in the program. As proposals to fundamentally alter the Medicaid program are advanced and debated at the federal level, we thought it was important to understand the impact of these proposals on Connecticut. Without such an understanding, the discussion is abstract, focusing on terms and concepts such as budget allocations, spending growth rates, dual eligibles, optional and mandatory beneficiaries and services and flexibility. What does all this mean and especially what does it mean to the residents of Connecticut? What do we think about these issues? This is our focus this morning. To help us learn more and provide background for the discussion we'll be having later, we are privileged to have with us three experts on the Medicaid program and the current proposals. First up will be David Parrella, Director of Medical Care Administration at the Connecticut Department of Social Services. David is not only our own state Medicaid Director, but also the current president of the National Association of State Medicaid Directors. He has been deeply involved in discussions on changing Medicaid and will take us through some of the issues that underlay the current proposals to restructure the program. Following David will be Joan Alker and Cindy Mann. We are very pleased that Cindy and Joan are here with us today to share their knowledge and expertise. Joan is a senior researcher and Cindy is a research professor at Georgetown University's Health Policy Institute. As you can see from their bios and actually just to note, all the bios are in the program, I'm not going to go through the background of all the presenters this morning. Both Cindy and Joan have worked in a number of capacities to improve access for low-income families and others throughout the country. A draft of their new paper "Federal Proposals To Restructure Medicaid: What Would They Mean For Connecticut" is also in your packet and they will walk us through their findings on the effect of the federal proposals on the Medicaid program. Following Joan and Cindy we will have a panel of state respondents who will give us their own perspectives and from the perspectives of those they represent and then we'll have ample

time for questions. So, at this time I'm going to turn the microphone over to David Parrella who is going to get us started. Thank you.

David Parrella, Director of Medical Care Administration for the Connecticut Dept. of Social Services

Good morning to everyone. Note to my mother, your cab will be out front at 10:30. Before I was the Medicaid Director I used to be an anthropologist. During that exciting phase of my life I had the privilege of working in Peru in a health development project where my role centered on the study of how innovations in health care delivery were adopted by and incorporated into the traditional systems of health care. As part of that study I became familiar with what anthropologists call the concept of limited good. It is a concept that is totally antithetical to our high-tech individualized notions of progress but is one that aid projects working in peasant societies ignore at their peril. Basically the theory states that in traditional agrarian societies, people do not see the world as containing boundless opportunities for self-improvement. The world is regulated by the natural progression of the seasons and the harvest. The social order that they live in contains cultural mechanisms that tend to level the amount of wealth or benefit that any one individual can expect to enjoy. Large-scale projects are organized communally. If an individual does attain some measure of material wealth or acquires some new technology, there's tremendous social pressure to divest him or herself of this newfound benefit through leveling measures like sponsoring the next fiesta in honor of the local patron saint, events that can leave the individual penniless but basking in the honor of his great contribution. It's the same with health care. People in the villages were anxious to purchase whatever new pharmaceuticals make their way up the mountain, but they're also leery of plans that seem to convey enhanced health status on some but not all. Any initiative that seems to elevate the health or social status of one member of the community is considered to have a potentially negative effect on the community that does not share in the benefit. It's more than social envy, although that's certainly part of it. It's more than a fear of new technology. It goes to the very basic worldview about the good things in life, but there's not an inexhaustible supply, that in fact the supply is fixed according to some combination of natural and magical forces. People who set themselves apart from this worldview are viewed with suspicion of anti-social behavior, or worse, witch-

craft. The title of my talk today is “Medicaid: A Program With Limits?” I’m telling you this story today because of what it says about how different people can view the same problem with very different perspectives on the concept of limited good. In the Medicaid context, that limit speaks to how you view the ultimate purpose of the program. Congress created Medicaid in 1965 as a seven-year bridge to the enactment of a full national coverage for low-income Americans. While Congress was able to assume that burden at the federal level for the elderly and disabled under Medicare, however imperfectly, it has not been able to adopt a consistent policy on what the ultimate purpose of Medicaid is, or will be. That hasn’t stopped the states from using Medicaid to fill in the gaps in coverage, in financing, in 54 different programs scattered across states, Indian reservations, territories and the District of Columbia. Clever Medicaid directors have used state plan amendments, waivers, inter-governmental transfers, provider taxes and hospital disproportionate share payments to leverage an ever-expanding commitment of the Federal Treasury to help fund services and individuals who the private sector cannot or will not cover. And, it’s worked. Medicaid is now the largest payer of health care services in the country. Even with the eligibility cuts that have already taken place in these uncertain economic times, it is now providing coverage to over 51 million Americans, more than the Medicare program. Over the next 10 years, it’ll expend over \$10.7 trillion dollars from the Federal Treasury, again, more than the Medicare program. This year it will spend over \$85 billion dollars in wraparound services for the so-called dual eligibles, those individuals who are eligible for both Medicaid and Medicare. That includes \$5 billion in Medicare Part B premiums, \$20 billion for prescription drugs and over \$60 billion for long-term care. And, yet, there are signs that this unofficial momentum has slowed, or may even be reserved. All across the country the expansions enacted during the go-go 90’s are running up against the realities of declining state revenues that haven’t kept pace with the rate of growth in Medicaid spending. States, including Connecticut, have been forced to roll back eligibility expansions recently enacted, eliminate coverage of optional services, put in place more stringent utilization review, cut provider payments and downsize program staff. It isn’t fun to do any of these things, in fact, it’s quite painful, especially when one has been involved, as I have, in putting in place the very enhancements we are now taking away. But, the reality is that we fundamentally miscalculated the ability of the system we put in place in the good times to sustain itself during bad times. The temporary increase in our federal match is much appreciated and will certainly help. But, it does not alter the equation that we are under an allotment system right now. That allotment is not on the federal share. It is imposed on our ability to raise our state share of expenditures to draw down federal funds. The speakers who will follow me, who are respected colleagues, will show you in graphic detail what impact this or that allotment scenario would have on federal funding for Medicaid

in Connecticut. But, the harsh reality is you have to pay the piper sometime. If you cannot afford to appropriate the state funds to sustain or to expand your programs in a gross budget state like ours, the vehicle that you use to access federal funds is somewhat academic. Now, there are plenty of consultants out there who are eager to spin gold out of straw by making the federal match appear with little or no investment of state funds. Medicaid directors are a highly suspect group in the eyes of some people because we have learned over the years, various ways to draw down these funds in ways that provide as much advantage to the states as possible, all within the limits of the law, of course. Hospital disproportionate share payments, inter-governmental transfers, waivers, provider taxes, targeted case management, the rehab option, all of these are ways to maximize the federal exposure in the financing of the program while minimizing any new contributions from the state general fund. In Connecticut the funds that we have been able to access have actually been used to support a broad network of health services that we provide and all of you should be proud of. However, there are signs that federal budget officials are uneasy, uneasy that the states continue to pursue these agendas while they are asked to pursue temporary relief to the current fiscal crisis. Everyone understands that the system of health care for the poor needs more money, but have we all been up front about what that money is for and what our goals really are? The answers to those questions are, in the end, what is really at the heart of the debate on Medicaid reform. To my way of thinking, the key provision in the reform proposals that have been discussed has to do with the calculation of the difference between the rates of growth and the state maintenance of effort, known as MOE, and the growth in the projected federal share. The state MOE would grow at a slower rate than the federal share. For some governors who are concerned about their ability to sustain their existing obligations, this gap provides a comfort level. To our friends at CMS (Centers for Medicare & Medicaid Services) the budgeted growth in the federal share ends the gaming of the match rate by the states. What new expansions could occur would be driven by the flexibility to target benefits to discreet populations in a waiverless society without the obligation to provide the all or nothing coverage currently provided under an entitlement program. If your vision of the program is innovation and coverage, this option is attractive. If your goal is expansion via the entitlement system, the implications of this are unsettling. You have to ask yourself what your vision of the program really is. So, assuming we’re not about to see any initiative for universal coverage anytime soon, except maybe in Maine, here’s my outline of what a deal on redefining the rolls of state and federal governments and the financing of health care could be. First, Medicare benefits must be modernized or the cost of caring for the dual eligible population will continue to inhibit the path to broader reform at the state level. This was one issue on which there was absolute bipartisan agreement in the NGA (National

Governors' Association) Task Force. Across the country, states are now spending between 30 to 40 percent of their Medicaid budget on dual eligibles, including the cost of prescription drugs, home care, nursing home care and Medicare Part B premiums, this for a population that accounts for perhaps 15 percent of the covered population. This doesn't mean we want to take away benefits from senior citizens, but it does mean that Medicare needs to change fundamentally, how it delivers and finances services before the Baby Boom generation begins to come into benefit. These changes include lifting of the more restrictive definition of homebound that Medicare uses in determining coverage for home care, the financing of a meaningful prescription drug benefit, full federal funding for Part B premiums for qualified Medicare beneficiaries and allowing the states to count the savings that waiver demonstrations create for the Medicare program in their own test of cost effectiveness in Medicaid. Second, states need more flexibility to implement something less than the all-or-nothing approach to coverage offered under the current state plan options. Something like a basic benchmark coverage for the working poor should be available without a waiver. This would strengthen the delivery of health care in the private sector, it would save both the states' and the federal government's money, it would reduce the administrative costs and it would mitigate against the eligibility cutbacks that most states have had to endure during bad times. Saying that this is an option now under a waiver that takes two years to develop and implement isn't good enough. Third, all waivers to encourage the delivery of services in the home as an alternative to institutional care should be converted to state plan options. Any waiver approved in any state that has been renewed once, based on a program review by CMS should immediately be available to any other state. Fourth, states should have the ability to fundamentally streamline and simplify their eligibility systems based on a means test that would collapse the morass of boutique coverage groups. That eligibility system should address the institutional bias that has always made it harder for a client to qualify in the community than if they reside in an institution. Fifth, states should have the ability to allow clients to self-direct their care as much as possible. And, finally, we should never lose sight of the fact that Medicaid is supposed to be about the entitlement of the client and not the entitlement of providers. How would we finance this system? For those clients that the law defines as mandatory eligibles, all of their protections for mandatory services should stay in place as they are today. Federal funding should continue according to the existing matching formulas. In Connecticut this is a surprisingly small portion of our total Medicaid budget. For the optional services, including pharmacy, the federal match should continue, but the states should have additional flexibility on the management of the benefit. For the optional populations, including any expansion groups, that are made eligible as a result of an eligibility simplification, states should have the option of providing a benchmark coverage package based on

broad parameters subject to approval by CMS. It would be up to the states whether they wish to continue a match for this population or if they chose to provide such care under allotment. Administrative costs should continue to be matched by the federal government, including the option of an enhanced match for new computer systems to encourage the states to stay current with new technologies. Finally, all the rest of it, the DSH (disproportionate share hospital) payments, the intergovernmental transfers, the unspent SCHIP (State Children's Health Insurance Program) allotments, all the money for services we currently cover that fall outside a benchmark coverage for optional populations, all of that should be identified and placed into the allotment and trended forward with maximum flexibility for how it is spent except that it must be spent on health care services for low income populations. Despite the fact that there is no consensus as yet on the path to broader Medicaid reform, this hasn't been a bad year for the states. We're grateful that Congress did decide to provide five quarters of additional federal match. In Connecticut the additional \$132 million in federal Medicaid funding will help to retire our looming deficiencies over the next two state fiscal years. We also appear to be on the verge of the enactment of prescription drug coverage under Medicare. While the version that is currently being discussed defers any action on prescription drug costs for the dual eligibles, it would provide significant fiscal relief for those costs that we currently incur on behalf of those recipients who are enrolled in our state financed ConnPace (Connecticut Department of Social Services Pharmaceutical Assistance Contract to the Elderly and Disabled) program. If enacted as currently proposed, we'll have to investigate how our state program could be adapted to provide a wraparound benefit for the monthly premiums and deductibles for those beneficiaries who enroll in the new plan. The proposed legislation also does relieve the states that participate in this new program of the obligation to pay the Part B premiums for the QMBs (Qualified Medicare Beneficiaries). This would save the state of Connecticut approximately \$35 million a year. This is neither the beginning nor the end of the discussion about the state-federal partnership on the financing of health care. These discussions will, in all likelihood, provide job security for people like me and Cindy for many years to come. I would close by reminding all of us of the reasons we continue to struggle with these issues. There are people in your neighborhoods and in your place of work, they are the soldiers in Iraq, many of whom grew up on Medicaid, they are people in our nursing homes and the people who care for them, they are persons with disabilities who want more control over the services they receive in their home. All these issues deserve our attention and states have had and will continue to have a legal obligation to deal with them. And, as health care costs continue to rise in a troubled job market, more and more Americans may find themselves joining the ranks of the uninsured. If Medicaid is not going to become our national health insurance,

it must have the tools to respond to this crisis in coverage, in good times and in bad. More money in the short term will certainly help, but it's not a short-term problem. It now seems likely, and logical, that we'll have to address Medicare reform before we get to Medicaid, but at some point we need to have the courage, as a national, to confront the question of just what it is that we want the Medicaid program to be. Thank you.

Judith Solomon, Executive Director of the Children's Health Council

Thank you, David, and there's no cab for you. You're going to stay around and be here for questions after the rest of the presentations. I think Joan and Cindy are going to come down and start the PowerPoint. People that are way on the side there may want to move to the middle because I'm not sure you're going to be able to see this screen and there are a lot of seats over there.

Joan Alker, Senior Researcher at Georgetown University's Health Policy Institute

Good Morning, everybody. Let me start out, I'll go to the next slide, I wanted to talk for a minute before we start with the slides about why we're here today. I was actually born in New Haven so I'm thrilled to be back in my home state, but besides that, why am I here today. Really there has been a lot of discussion in Washington about Medicaid reform this spring. It started when the President released his budget in February of this year where he had a substantial proposal to restructure Medicaid. Subsequent to the release of that proposal, the National Governors' Association was asked to endorse it in their February meeting and they did not endorse it at that meeting, instead they decided to form a Task Force that would come with some kind of alternative recommendation on reform. This Task Force has been working for many months. It was a bipartisan task force, five Democrats and five Republicans and Governor Rowland was on the Task Force. Just as of last week the Task Force was unable to come to any bipartisan agreement and disbanded. But, there have been a lot of discussions and Governor Rowland has been very active in these conversations. He testified before Congress earlier this year about the President's proposal and he's been a very strong supporter of the President's proposal. That's why I think there was particular interest in how would this proposal would affect Connecticut, because as some of you may know, the President's proposal is an option for states. States would not be required to participate in the block grant system of funding, but I think because Governor Rowland has been a very vocal supporter of it, one might therefore assume he might wish to take advantage of that option. So, I think that's why it's particularly important to think about what would it mean for Connecticut. OK, we're going to start with the slides today. David already did, I think, a great job outlining some of the key features of Medicaid, so I'm going to be briefer here, but as he indicated Medicaid now

provides coverage to more people than Medicare, which I think is surprising to many people. Here in Connecticut it covers almost 400,000 people. Who are the folks on Medicaid? Well, the largest single group is kids. There are 26 million nationally, just over 200,000 here in Connecticut. Their parents, 13 million nationally, are the next largest group. Here in Connecticut it's about 89,000. Then there are folks with disabilities and seniors, 8 million nationally, 5 million seniors, and as David mentioned there's a very significant and costly chunk of beneficiaries who are so-called dual eligibles. They're eligible for both Medicaid and Medicare. I'm not going to spend a lot of time on this — it's in your packet. But this goes through who are the mandatory coverage groups and who are the optional coverage groups in Medicaid. Here you see just again a graph of who's covered in Connecticut. Some of that reflects mandatory coverage, but in all of your categories there's a reflection of optional coverage, choices the state has made. So, while the children and the parents are the majority of the folks on Medicaid, seniors and people with disabilities account for a good chunk of the cost and here in Connecticut a higher share than the national average. You can see on this chart that they're 27 percent of the people on Medicaid, seniors and people with disabilities, but here in Connecticut they constitute almost 82 percent of the cost, so that's very significant and that's important for reasons we'll come back to later when we talk about the President's restructuring proposal. Let me talk briefly about some of the key features of Medicaid. As David mentioned, it's jointly financed by the states and the federal government, the federal funds are paid to the state on a matching basis, and what that means is for Connecticut for every dollar the state spends, they're guaranteed to get back \$0.50 on the dollar. For the CHIP spending they're guaranteed to get back \$0.65 on the dollar, but the CHIP program overall is not an open-ended source of federal financing, it is a capped program, unless the state chooses to go with the Medicaid option, you can go back to regular Medicaid rate, but that's a significant difference in the CHIP financing as opposed to the Medicaid financing. But, in Medicaid, the federal funding is available on an open-ended basis and there is currently no cap. As a condition of receiving these federal funds, states have to operate their programs consistent with the federal requirements and options. It is an entitlement to individuals. That means a state can't impose a waiting list in the Medicaid program and there are minimum standards on eligibility, benefits and cost sharing. I wanted to call your attention to one. We don't have a slide for it, but there is a chart in our paper that looks at the Medicaid benefits package and how does it stack up to a private, commercial benefit package. David mentioned there's a lot of interest in moving, particularly optional beneficiaries to a "benchmark" standard that might look more like private insurance. I think there's actually a lot of sort of confusion and sometimes misinformation about what is in the Medicaid benefits package for adults. For kids the EPSTD (Early & Periodic Screening, Diagnosis &

Treatment) benefits package is a very broad benefits package that's required. But for adults, if you stack it up against a commercial package, many of the optional services, many of the mandatory services are very similar to what you'll see in a commercial package, but the optional services are services that are very important, particularly for people with disabilities. That's really why we have Medicaid, because a lot of those folks aren't able to get the coverage in the private market that they need. Again, David mentioned this. Medicaid is a very major component of any state's health care system. It accounts for nearly 17 percent of the nation's health care expenditures. It is the single largest source of federal financing to states and this year it's estimated Connecticut will receive \$1.9 billion in federal Medicaid funds. It is a key financial support to many safety net providers, hospitals, health care centers, and it also contributes to the child welfare system by covering kids in foster care and other parts of the state budget. And, Medicaid provides jobs. It's a real economic engine for many communities, particularly smaller ones. Medicaid costs are growing, as you all know, Cindy's going to talk more in a minute about historically how Connecticut Medicaid costs have stacked up, but this year Connecticut's Medicaid spending is projected to grow by 8.7 percent. That's similar to the national average, although historically Connecticut Medicaid has risen at a much slower rate than the national average. Why is spending growing? Well, health care spending is growing across the board. Private coverage costs are going up, but for Medicaid actually, if you look at how much of it's attributable to an increase in enrollment, because of course we've been in a recession and Medicaid is a key safety net, so you'd expect enrollment to go up, but the per capita costs in Medicaid actually haven't gone up very much. They've gone up much slower than private insurance, but there have been more people in Medicaid, and of course many things, like prescription drugs, all of those areas, we're seeing costs go up. As you all well know, states are facing severe budget pressures. That's been a real challenge as Medicaid costs go up and revenues are going down. Not only are seniors and people with disabilities the largest share of spending, they're also the fastest growing share of Medicaid spending and this, I think, is a good chart to display that. This shows you how dramatic the decline in state revenues have been. I think this is important because we talk a lot about Medicaid costs going up, but on the flip side of this, state revenues have declined so dramatically that that's what has caused this incredible budget situation that many states are facing. Ok, let's go to the President's proposal now. I'm going to try to be fairly brief. You heard some similar components described by David. Essentially what this would do is fundamentally restructure the financing for at least the optional piece of federal spending. Now, optional sounds like oh, it's optional, ok, oh, what's the big deal? In fact, optional spending is about two-thirds of Medicaid spending, so this is a very significant chunk of the federal funding that would fall under the cap and essentially what the proposal does

is that it imposes the cap and offers some up front money to states. But in the out years, it's a ten year budget proposal. The growth rate in the federal spending would be lowered, so essentially states would get a little bump up in the front, but in the out years they'd essentially have to pay it back and that's, I think, very problematic. The cap would be particularly tight at a time when, because of the aging of the population, projections and growing health care costs, that states would really be facing increased demand for the most costly services, right when the cap would kick in and they'd lose their federal partner of the open-ended financing, so there'd be even more pressure on state budgets to have to pick up their share of the costs at that point. Under the allocation system, we'd no longer have a matching system for this optional piece of the funding. There would be maintenance of effort. This is a very significant piece and Cindy is going to talk about it later so I'm not going to touch on it too much, but it's very important. Um, there'd be very broad flexibility and I'll talk about that more in a minute. Let's talk for a minute about the capped federal payments, how would that get decided? What would the cap be? Of course all of this would be subject to legislation so there'd be a lot of negotiating about how would the cap be structured and how much money would each state get and there'll be a very complex set of discussions. But, essentially what the President's proposal proposes was to use 2002 spending as the base year to adjust it forward using 10-year growth projections and let me stop there to say that's an extremely hard thing to do, to predict what health care costs are going to be ten years from now it is an extraordinary challenging exercise. When we went back and looked at the Congressional Budget Office – they're essentially the score keepers of any federal legislation – how have their predictions been? We looked at the fiscal year 2002, did they get it right? We compared other projections from the 6-8 years prior, well, no, they never got it right, not once did they get it right and in fact they were in error by up to \$17 billion dollars. So, that's a very costly mistake that states could be left holding the bag for if the projection is wrong, which I think we know from history, it's probably going to be wrong. The funding would no longer be based on actual changes in enrollment, so if you had a recession your funding would still remain the same and you had more people on your program you wouldn't get any more funding which you do today. The funding would no longer be based on changes in health care costs, utilization or new technology, so if we had a new epidemic like SARS you wouldn't get any more money and this is something in the paper we talk about, for example the AIDS epidemic. Medicaid is the largest source of federal funding for treating HIV and AIDS. The program, because it had open-ended flexibility in its funding, was able to respond to the AIDS epidemic, but that would not be true under a cap system. The President's plan would give states very significant flexibility for optional beneficiaries and services both for mandatory beneficiaries and optional beneficiaries. So, what does this mean?

Well, optional services could be provided for some people but not others and that's true of all beneficiaries, mandatory and optional beneficiaries under the proposal, services that are optional could be covered, like prescription drugs is an optional service, could be covered in some parts of the state but not others. There could be closed formularies for drugs, certain drugs could be excluded even if they were needed. There could be higher cost sharing for beneficiaries and indeed there wouldn't be any limits in some of the versions of the proposal that we've seen for some groups of optional beneficiaries and services like inpatient hospital care could be dropped and there's a whole range of current federal protections like nursing home quality standards. Managed care protections for the optional beneficiaries it appears that those will be eliminated, but of course that'd be subject to Congressional discussion as to how that would continue. Those are the kinds of things that would be very much on the table. At this point I'm going to hand it over to Cindy so she can talk in more detail about how the proposal would affect Connecticut. Thanks.

Cindy Mann, Research Professor at Georgetown University's Health Policy Institute

OK, Part 2, and it'll be shorter. We're going to talk now about, take the aspects of the President's proposal that Joan laid out and talk about how those key elements of the proposal might fare in Connecticut and let me say initially that the proposal, as Joan described, would fundamentally change the federal-state relationship and key elements of the proposal. Every state would be affected dramatically at least every state that opted into the block grant and even in some respects states that didn't opt into the block grant for reasons we can explain later if anyone's curious. And, each state's going to be affected in its own, unique way. It's difficult to say exactly how different states would be affected as Joan said. Any proposal would still make its way through legislation and Congress and likely change. But when you look at some of the specific factors that are unique to Connecticut, you see some signs of ways in which some of the elements of the proposal would place particular stress on Connecticut and its ability to provide health care services through its Medicaid program. So, we're going to talk about four specific areas which we call risks, to explain a little bit about how the proposal might impact communities generally and then how specifically Connecticut may fare. So, if we could go to the next slide. So risk No. 1 that we're talking about is capped federal payments. This is the fundamental element of capped federal payments is that it shifts the financial risks of higher than anticipated growth in costs to the states. It's not unique to Connecticut. It would happen to any state that opted into the block grant system. Right now if you have higher costs in the Medicaid program as Joan explained, the federal government shares those higher costs. Under a capped system, you have your capped federal payments, so if there are higher than anticipated costs, higher costs than what are accounted for

under the cap, the state absorbs that risk solely. The state can either pay for any additional costs with state only dollars or the state can use its new flexibility under the block grant to change the program to be able to live within the capped amount of money. So, the fact that the costs are shifted to states isn't unique to the Connecticut situation. It would happen to all states. It's really the fundamental change in the program under a block grant. But, we thought that, when we looked at the numbers in Connecticut, one aspect of Connecticut's spending underscored to us that the risk is really particularly great in Connecticut because a very large share of the state's spending would be under the cap. As Joan has explained, if you can go to the next slide, and David talked about this as well, nationally about two-thirds of all spending is on optional people or optional benefits and that's the spending that would be under the cap under the President's proposal, again, this is pre-legislation, so things could change. When you look at what goes on in Connecticut, as David has noted, if you can flip to the next slide please, Connecticut has an higher than average share of optional spending. Was it really impossible for us to look at how much optional spending versus mandatory spending Connecticut has? Because actually it's a distinction without a difference in the way the Medicaid program operates now in terms of once you're implementing your program, optional services are provided, optional beneficiaries are covered and the state doesn't keep separate distinctions on those benefits and beneficiaries, because there's no particular reason to. But, we were able to pretty much identify who's an optional beneficiary from the elderly side and with respect to people with disabilities and compare the spending on those two groups which is the big chunk of the spending in Connecticut as in other states, so the average, national average, in terms of optional spending and what this graph shows you is that Connecticut spending on optional people, the elderly and disabled side, is much greater than the optional spending for the national level. That's for a variety of reasons we go through in the paper. You have a somewhat higher portion of elderly people in Connecticut than in the nation as a whole and your spending per elderly beneficiary and per beneficiary who's disabled is much higher than the national average. So, the point is that a much larger share of the spending in Medicaid and the Medicaid program would be under the capped payment. So when you talk about states would bear the risk of higher than anticipated costs, in Connecticut you'd bear the risk of a much bigger share of your Medicaid program than would many other states and most other states when you look at the national average. Risk No. 2 that we wanted to talk about is the growth rate. As Joan has explained, in the President's proposal, states would get an allotment, an annual allotment. It would start off being based on the spending in the state, the federal spending in the state in 2002, both from the Medicaid program and the State Children's Health Insurance Program. Then, the payments would grow each year over this ten year period so the question

is not just how much would you get in your base payment, but what would be the rate of growth for each state and every state will be acutely concerned about what rate of growth they'd be assigned under the block grant system. Nationally, the President has proposed, well, all the money that would go to states would grow that the rate that they're now projecting Medicaid will grow for the next ten years, so they're projecting, CBO, the Congressional Budget Office, projects a rate of growth averaging about 9 percent over the next ten years. So they're saying we're willing to spend that amount of money on the block grant payments to all states over that period of time. But, then the questions is, is that rate of growth going to be accurate, and then, how do you take that capped amount of money at the federal level and divvy it up among states? So, let's look at the first question, which is is that amount of money going to be adequate? Joan mentioned the CBO estimates have been off regularly in terms of federal Medicaid spending and state estimates are off equally, it's not to chastise or target the Congressional Budget Office, it is in fact notoriously difficult to predict health care spending, not just Medicaid spending, but health care spending overall. So, the first point that Joan had made earlier is, will this 10-year allotment that's available to all states be adequate given that it's based on projections that we make in 2003, but we'll all have to live with for the next ten years and this shows that the CBO was off by 12 percent, that accounted for \$17 billion when it made its projection in 1998 relative to 2002. But, let's assume for a minute that the amount of dollars are adequate, then how much would each state get in that capped amount of money? Well, through some of the negotiations with the Governor's Task Force, the President's proposal moved off of giving state's a one size fits all growth rate, which I think is a good thing, since state's are quite unique in terms of how their expenditures have changed over the course of the years, and pretty much had decided that there'd be state specific growth rates, so you take the capped amount of money and you divide it up and you look at state's historical growth rates, ok, what else could you look at objectively to project forward? You'd look at what a state's growth rate has been in the past and you say, well, based on the state's historical growth rate, here's what we'll give your state in terms of your growth rate for the next ten years. When we looked at Connecticut's expenditures and growth rate over the last few years, I'm sure it'll seem surprising to people here because you're grappling with the squeeze in terms of your Medicaid program and your declining revenues and it feels like Medicaid is out of control, but the growth rate has actually been much slower in Connecticut than in the nation as a whole. We looked at the last, since 1993 to 2001, which is the last set of years for which we have national data, and then looked at specifically two periods, broke up that longer period into two periods, '93 to '97 and '98 to 2001. If you look at the '98 to 2001, Connecticut actually ranks near to the bottom, I think it's 49 out of 51 states in slower growth rate. It was about 5.36 per-

cent over that period, and if you look at that longer period it was 5.10 percent. We stopped at '93 because of some of the DSH activities that some states embarked in and that skews the data, I think before 1993. Connecticut presumably would have a capped allotment set based on its 2002 payments, it would grow over the ten-year period, but it would grow based on those lower than average historical rates, presumably, again, it's all subject to negotiation and final legislation, but that's where the proposal stands at this point. So, you'd have a particularly tight cap, one that would grow less robustly than even the national average. So, that's bad enough, but worse yet is that historical growth rates are not necessarily good predictors of future growth rates. What we did is we looked at, if you'll look at the next slide, is we looked at that period between 1993 and 2001 and broke it up into the two 4-year periods and what you see on the left side of the table are the states that ranked at the bottom.....

(END OF TAPE 1 SIDE A)

...growth rate just in the following four years and you see a couple of states ranked low in both sets of years, but you have three states, Kansas, Oklahoma and Indiana that were in the lowest ten states in growth rate between '93 and '97 that were among the ten highest states among growth rate between 1997 and 2001. Alright, so, again, you have a cap, the cap doesn't change, the cap is based on some assumptions of growth rates, but whether those assumptions are going to be good assumptions for Connecticut are very questionable based on what we see in terms of both Connecticut's history in terms of expenditures as well as the history in other states. Risk No. 3 that we wanted to call your attention to is not uncommon to, not unique to Connecticut but one that I think people here will particularly want to think about is that it changes fundamentally the fiscal incentives to maintain investments in the program. People say, often, that, well, if it's optional spending under current law and it would be optional under a block grant, what's the difference, what would change? States have decided in the past to do options, sometimes they pull back, sometimes they restore the options, why would it change under a block grant? It changes under a block grant both because the rules of the program would be different, but also because the fiscal incentives would change dramatically. It's really important to focus on the fiscal incentives. David and Joan have both mentioned that, if you want to turn to the next slide, that one feature of the President's proposal is that it would end the matching system and replace it with what's called a maintenance of effort system. If people understand the Temporary Assistance to Needy Families program, that now has a maintenance of effort system and the old AFDC (Aid to Families with Dependent Children) program had a match system. Let me just explain briefly. Under today's Medicaid program a state pays for the expenditure and the federal govern-

ment matches that expenditure according to the match rate. So, the state has to commit its dollars. The federal government matches that commitment according to whatever the match rate is for a particular state, in Connecticut it's 50-50. Under the President's proposal your federal dollars wouldn't match your state dollars, you'd simply get your allotment based on how much you spent as long as you spent at least "X" amount of dollars in state dollars. OK, and that "X" amount is less than what a state would spend if we still had the current system in place. That's not just my calculation that it's less, that's the design of the proposal and that's the feature that David mentioned that has a lot of attraction to governors, which is to say "you'll get your full allotment and we'll let you put in less state dollars than you would have spent to get that same amount of federal dollars under current law." Alright, it's the other fiscal incentive, it's the other carrot that has been touted by the administration to encourage states to be interested in this proposal and of course in this budget time it's very attractive to states. They can say, wait, right now when I pull out state dollars I lose federal dollars. Under this proposal I could pull out state dollars and not lose federal dollars, so it definitely has its attractions, but, let's think about what it does in terms of this notion of investment and optional coverage. We did a calculation looking at what the potential loss in funding of state dollars now, this is apart from a cap on the federal dollars, the potential loss in state dollars for Connecticut over the 10-year period of time and we came up with two different estimates because we don't know what the spending is going to be in Connecticut over the next 10 years. So, the low estimate assumes the rate of growth of spending in Connecticut would be about the same as that 5.36 percent that we saw between 1998 and 2001 and the higher estimate shows the projection if Connecticut's spending is more similar to the federal projection for Medicaid expenditures. It could be higher, it could be lower, it could be somewhere in between, but you see, in this graph, that there's a substantial potential for states to be able to pull out their state dollars and not lose a penny of their federal allotments. Now, I will say that I think some of this is dreaming on the state's part, if you're going to live with a capped allotment and you have an aging population and your federal dollars aren't growing in the way that your costs are growing, you may not, in fact, be able to pull out those state dollars. You just simply might not be able to do that. You're going to have to make up for a federal shortfall. But, the potential is there to pull out those state dollars. Let's look at the fiscal incentives then to cover optional services or optional populations. Under current law, if the state decides to pull out \$120 million in state funding for its Medicaid program, I'm going to cut out an optional service, cut out an optional benefit category, it has to think under the 50 percent match rate, it has a higher match rate if it's doing this under CHIP. It has to think, well, if I pull out \$125 million in state dollars I'm going to lose \$125 million dollar in federal dollars. That doesn't stop a state from pulling out its funding and optional services and

optional benefits as we've seen. States, Connecticut's been doing it, other states have been doing it, but it certainly slows them down. It certainly makes states rationally think twice about whether or not to curtail their optional coverage for people. That's how the Medicaid program works. It really does work more on options than on mandates. It presents options to states and gives them a fiscal incentive to invest in those options and to maintain their investment. But, look what happens under a block grant proposal. State says, "I can't afford my \$125 million," or, "I've got some other priorities, I want to pull it out." As long as it's meeting that maintenance of effort allowance requirement, it could pull out the state dollars and not lose any of its federal allotment. Again, some people might see that as a real benefit, some people might see this as a real danger. I think whatever way you look at that set of figures you have to recognize that the incentives a state has to invest in its optional population and its optional benefits changes dramatically under a block grant. It is not optional, the sense of optional means something very different under a block grant financing system. The last risk that I just want to run through is then what happens. You have the potential of a federal shortfall squeeze because of the cap on federal dollars. You have the potential of a withdrawal of state dollars in the system. Then you have broad new areas of flexibility given to the states to manage within those reduced federal financial commitments and Joan has run through what some of the opportunities would be to change some of the rules in the program and we can talk through it. What we looked at, and Joan has gone through this as well, is if you look at the next line please, Medicaid expenditures in Connecticut, like other states, is very highly skewed towards the elderly and people with disabilities. They are the high, people with high health care needs and high medical costs. Nothing surprising, nothing particularly unique about that situation. Connecticut is even more skewed however because of your relatively high spending per person, particularly for nursing home care. So, what you have in a block grant, fundamentally, is a zero sum gain. What you have in Connecticut is a high proportion of your expenditures for people with disabilities and elderly people, a very small relative chunk of the expenditures for children and for parents and so what is the state going to do? It's going to look at its spending and it's either going to cut people who are most vulnerable, people who need those services the most, people who have disabilities, people who are elderly, cut into nursing home provider payment rates or the people who are eligible to go into nursing homes, or they have to cut children and adults very deeply because there's not much spending there. There are a lot of people there, but there's not much spending there. That's fundamentally what you need to think about. Dave is absolutely right that there's competition for limited dollars now on the state side. We all know that. We hear all the time, figuring out the priorities and helping our elected leaders to figure out the priorities on the state spending, but also in a block grant world not only are you competing for

those dollars in the state level, but then you're competing for the dollars on a capped level in terms of your federal dollars. So, I would suggest that it exacerbates that competition and that sense of limited resources much more than what we have under the current system. I'm not going to go through, our paper goes through what some of the alternatives are. I thought David did a very thoughtful job thinking through what some of the directions are that we could go, because whether or not this proposal moves through Congress, I think there's no question that the discussions that we're having at the state level, the discussions we're having at the federal level, show that there needs to be some changes in terms of how health care is financed. We've known for a long time we need some changes because there's some 41 million people who don't even have coverage at all across the nation. So, there are a number of alternatives to think about. Some of those alternatives have to do with making some changes inside the Medicaid program. David talked about perhaps changing the benchmark coverage, what the rules are for optional adults. I think there's a set of changes in the Medicaid program that probably most people could get in the room and agree to. I think there are a lot of changes in the rules in the Medicaid program that there would be a lot of disagreement about whether they are good changes or bad changes. My encouragement to all of you is to pay attention to the details. We can't have the discussion about Medicaid flexibility in the abstract. It always sounds nice to get rid of those constraining federal laws. Sometimes those federal laws are constraining. I was at the federal level for a while and as we all know, sometimes they are bizarre. But, sometimes the federal standards make a big difference. The EPSDT rules, the coverage of children, some of the cost-sharing protections that are in place have made an enormous difference in the lives of people, so we need to pay attention to the details. It's not true that more flexibility is a good thing or a bad thing, it's true that some standards need to be there in my view on the federal level and some ability to be flexible at the state level is quite legitimate. So, we need to have that debate. We also need to think about the Medicare program as part of the solution to Medicaid's problem and it's a big part of the solution if you look at the next graph. David talked about this, is that 35 percent, this is a shocking amount to most people, 35 percent in the national average of Medicaid's money is spent on people who are Medicare beneficiaries. It's a shocking amount. Medicaid is doing double duty. It's not only covering the people under Medicaid, but it's also filling in the very substantial gaps and expensive gaps in coverage in the Medicare benefit package. So, whether it's prescription drugs that come through the Medicare benefits or whether there's some great assumption of federal responsibility over long-term care, those are, that's not small change items, if we get some real changes, not only might people get better benefits through the Medicare program, but it'll provide significant fiscal relief depending on how it's done to states on the Medicaid side. So, that's a big issue. The other areas that I think we all need to look at is

beyond Medicaid and beyond Medicare – pricing of prescription drugs, generally, there's a lot of things in our health care system that need to be changed. Medicaid's issues are only a reflection of larger health care cost pressures and nothing particularly unique to Medicaid other than it's a safety net and it does grow in times of recession because more people rely on the program. Largely we need to think of the solutions as, what are the problems here. We don't see a problem of overspending in the Medicaid program by and large. We see it largely as a resource problem, that state revenues are falling, health care costs are rising and Medicaid is doing double duty and we know that we need to deal with many of these resource questions, while of course making the program more responsive to the changes in the marketplace and who Medicaid is covering. I'm going to just flip to, keep going down a few more, the next graph. I guess I want to close with two things, or it's really two parts of the same point, which is, we have this debate, now, largely on fiscal terms, we've got a budget deficit, we've got to deal with our shortfalls, we've got to deal with our incentives, we should have caps, I'm with you on that. My presentation is largely about the fiscal incentives and the fiscal risks that come about, but we can't lose sight of the fact that Medicaid and the children's health insurance program has really made a difference. It provides health care coverage to people and that's been a good thing. That's what we were all working for over the last few years and we can't lose sight of the fact that it's actually done a good job. I picked a couple of states for which we had some more detailed data. This looks at two states that have pretty much the same levels of employer sponsored coverage. Not all states come to the problem of lack of insurance coverage with the same basis, right? Some have stronger employer based coverage in their states, some have less, so here's, New York and Texas that have about the same level of employer-sponsored coverage among low-income people. Low income, non-elderly people, but you see the uninsurance rates in those two states are very different. The uninsurance rates in those states have to do with a lot of things, but largely the difference in those two bars is the investment each of those states have made with respect to public insurance, Medicaid and CHIP. And, New York has done a much broader investment using its Medicaid program and health insurance coverage, not dissimilar to Connecticut's choices, and its uninsurance rate has changed, dropped dramatically over time and relative to other states who haven't made that choice. And, finally, while we talk about health insurance coverage at the end of the day it's really about people getting care and you can look at lots of different research, it really shows you all the same things, notwithstanding the problems we all know that go on in access-to-care for people with publicly funded coverage, in general, people with Medicaid coverage get about the same access to care as people with private coverage and much less access to care than people who don't have health insurance coverage. This looks at a study by the Urban Institute, for women who left welfare, low income parents who are working who had health insurance

through Medicaid or who didn't have health insurance and big difference in who was able to see a doctor, who was able to get a preventative breast exam, who was able to get a Pap test, it makes a difference, that's why we're all gathered here to talk about it and we need to always keep that perspective as well. Thank you.

(Audience claps)

Judith Solomon, Executive Director of the Children's Health Council

Thank you Joan and Cindy. I'm going to turn it now to the panel. I'm going to introduce the entire panel. They're going to present from up there and then after that, Pat Baker, President and CEO of the Connecticut Health Foundation, is going to come down and moderate the question and answer period. Our panel consists of Bob Trefry who is the President and CEO of Bridgeport Hospital, Evelyn Barnum, Executive Director of the Connecticut Primary Care Association, Barbara Hunt who is a Medicaid consumer, and Margaret Morelli who is the President of the Connecticut Association of Not-For-Profit Providers for the Aging. As I said, they're going to make brief presentations from their own vantage point, reacting to the panel and then we'll open it up for questions. So, I think Bob is going to start us off.

Bob Trefry, President and CEO of Bridgeport Hospital

Thank you. I think as you've probably been able to tell from the first part of the presentation, Cindy and Joan did an excellent job of describing some of the problems the state Department of Social Services deals with all the time in terms of how to make sure they're providing coverage for the citizens of the state. You can also tell I don't have any hair left at all, you say, "Why Bridgeport Hospital on this panel?" If you look at the percentage, by hospital, of the percentage of their patients that are covered by Medicaid, we're the second highest in the state. About 25 percent of our patients that we see are Medicaid beneficiaries. As a result of that we also, because of our location, and you can predict by the number of people you have on Medicaid, we also have a lot of people who are uninsured. So, we're very much in the center of all these issues. I think the, it was said by Cindy at the end of the discussion, the issue that's really about coverage for people, it's really about providing, I think the discussion that has been proposed by the administration in Washington around this whole issue of providing. Flexibility and the caps is really about how to try to control the costs, or how to make the costs predictable for the federal government. It's not necessarily about how to make sure we have universal coverage throughout our country. That's really not the focus of the discussion. I think that's what the focus of discussion really needs to be on. In any given year, at any given time, we have about 41 million Americans who do not have health insurance. Over a 2-year period there's 75 million Americans

that at some point of time during a 2-year period do not have health insurance. These are people who end up in hospitals, and the folks who are on the panel are taking care of those folks without reimbursement at all during those particular times. So, I think we need to look fundamentally at how we are going to provide coverage. The World Health Organization did a study in the year 2000 about health, comparing health systems across the world. They said, one of their conclusions is that there are only two developed countries that do not have universal coverage for all their citizens. The United States and South Africa. The footnote at the bottom of the page says that South Africa actually has a policy to change it. We do not. As we're approaching this we look at how we control our dollars, we're not looking at how we're going to provide universal coverage for all the people in this country, whether they be elderly, insured, whether they be employed, whether it's a matter of private-public partnerships or private insurance or public insurance, we don't really have a strategy to do that. We're looking at how to control our costs in a time of economic stress. I think that the problems that are related to the proposal that's being put forward, I think from a provider's perspective, there are a couple of things that are particularly important to us. One is, as was pointed out, it really locks in historically low rates of reimbursement and cost. As was mentioned before the amount of increase that we're seeing in the state of Connecticut over the last several years has been lower than the state averages across the country. That means that provider payments have been lower than increases in those have been lower than other parts of the country. There's also tremendous disparity within our system. By locking in these rates and making this a block grant it takes out a lot of the state's flexibility in the future to be able to equalize the payment system. If you look from the hospital perspective, hospitals are paid about 74 percent of their costs on the average, but that varies from anywhere from 62 percent to close to 90 percent of what their costs might be. Unfortunately, it doesn't vary based on the amount of patients that one sees. Bridgeport Hospital, as I said, sees a tremendous number – 25 percent of our patients – the second highest percentage in the state, but we are at the lowest percentage of reimbursement, we're at 62 percent. So, there is inequity within the system – by block granting this you take out the ability to be able to correct some of those things in the future. All providers are really asking for is to be paid a fair amount, a fair amount for the patients they're taking care of. If you shift to making this a block grant, although the state gets some flexibility in the process of doing that, it will take on tremendous risk. They take on the risk of both increases in the number of people who would be eligible per insurance as our economic conditions deteriorate, we see more and more people who are applying for Medicaid, and will be uninsured in the future. They also take on the risk of technology changes, as new things become available to the population, the state takes on the risk of how those new technologies will be funded as well as was mentioned earlier about

things like AIDS and SARS, other things we don't know about that could affect the utilization of all the different services that are necessary to take care of people will also be affected if in fact there is not some matching of funds as opposed to a block grant in the future. I think if you look at this from a national perspective, we need to, if one said that we're going to take the Medicare program and we were going to make the Medicare program vary from state to state, you can because seniors are pretty mobile. They'd move to the state that had the best coverage. We have now taken the position in our Medicare program that we're going to make that a state option as to how they craft the coverage for people within each individual state for their senior population. We should not be doing the same thing in terms of our population who is our poorest folks in our communities. There should also be a way in which we're setting standards for that and making sure that it leads to total coverage for folks in our state, but not leaving it to the economic problems that each individual state faces. The state of Connecticut is no different than other states having to look at how they try to balance their budget. They do the best they can. The legislature and the administration struggle with those issues on how to do the best job they possibly can. We should not be putting the health care of our citizens in the middle of that whole discussion. That should be something that is taken out of that discussion in some fashion and made more consistent across the country so that states that are having economic difficulties are also not the ones that are faced with potentially having to cut back on coverage for some of their poorest citizens while the state is going through economic difficulties. This should be the time in which more dollars may need to be spent at that time because of the needs of their citizens. Those are the comments that I wanted to add to the discussion from previously.

Evelyn Barnum, Executive Director of the Connecticut Primary Care Association

The Connecticut Primary Care Association is the association of Federally Qualified Health Centers in the state of Connecticut and we have 13, they offer care at about 56 sites. They care for about 20 to 25 percent of all Medicare patients in the state of Connecticut so it's about 76,000 patients. But, 25 percent of all the patients at Federally Qualified Health Centers are optional beneficiaries. So, well and good that our services are mandatory, but if there is too much flexibility in who is covered in Medicaid reform, then the health centers are at great risk because we'd be adding, losing coverage for those patients to the already 33 percent of all health center patients who are uninsured which is about 54,000 patients. We've recently lost the coverage for our Husky A parents who are a significant number of health center patients, so instead of having an average of 33 percent of all health center patients uninsured, we're pushing that to almost double that number if this reform were to go in that direction, so the concern for the health centers

would really be around the optional beneficiaries, more so than the optional services. In the past, historically, flexibility hasn't worked out well for the health centers particularly. When we went to Medicaid managed care there was a lot of confusion among patients and it was very difficult for them to make the selection of their HMOs (Health Maintenance Organizations) and so overnight, health center patients unknowingly defaulted or elected into HMOs or MCOs (Managed Care Organizations) that didn't have contracts with their Federally Qualified Health Centers. So, the impact was enormous and it took them a long time to recover from that and then in 2001 when federal law implemented a prospective payment process for the health centers, again, the federal law didn't address the particulars of that reimbursement system, so the health centers have struggled a little bit with the implementation of the federal law and in many different states have fared better or for worse. So, rather than think of the health centers in the optional or mandatory category, I guess I'd like to think of them as essential to the Medicaid program in terms of the volume of service they provide and the fact that the federal law that defines Federally Qualified Health Center services includes a lot of important services that enable low income populations to access their care – there's outreach to let patients know they're there, there's transportation, there's translation and there's case management to facilitate the use of their services. So aside from the tidal wave that might hit the centers in terms of large numbers of uninsured patients, I think we're very concerned for them about the tone and the fact that we may again be talking about the reimbursement mechanisms and a lot of the details that Cindy referred to that would have a profound effect on their ability to provide the services. I thought David put it well when he said that Medicaid is an entitlement for the patient and not for the providers. But for the providers who are in Federally Qualified Health Centers to try to eliminate health disparities, which is the direction the federal government funds them to proceed in, I think it's important that we keep them viable and able to provide the services that their entitlement would provide. So, we will watch this closely and hope for the best.

Margaret Morelli, President of the Connecticut Association of Not-For-Profit Providers for the Aging

I'm Mag Morelli, I'm representing the Connecticut Association of Not-For-Profit Providers for the Aging and CANPA represents about 140 not-for-profit providers throughout the continuum. We're not just nursing home providers. It's providers of affordable senior housing, independent senior housing, home and community-based services right down through skilled nursing facilities and chronic disease hospitals. When we first heard the Bush administration was looking at block granting the Medicaid program we were actually a little bit optimistic, or wanted to be optimistic, thinking here was a chance to maybe change the system, the payment system, both

reimbursement and regulations, so it'd better serve the recipients as well as the providers of long-term care. This was maybe a chance where we could take away the patchwork system and make it a system where people received appropriate care in the appropriate setting, made the transition into the next setting much more fluid. So, we were really optimistic until we took a look at the program and the proposal. What really concerned us about the proposal was the caps and I know everyone's been talking about the caps, and particularly for the elderly population because as you saw from the two previous presentations, it's very large, the largest piece of the spending and it's the largest piece of the optional services and recipients and so it's the largest target to be cut in a cap or squeezed in a cap. So many of the residents that are served both through senior housing and the nursing home facilities are now currently receiving Medicaid benefits. So, every member of the continuum would be affected by this block granting. So, there are concerns on all levels. There's also the concern because there is no real trending for expansion. People are coming into the Medicaid program and as we all know not only is our aging population growing, but we're living longer. The people we serve in this portion of the benefit structure is just going to grow and if we do it right, and expand our ability to provide home- and community-based services and to provide more services at different levels, you're naturally going to grow the number of people who come into the program, because you want to get people in earlier, you want to get people before they impoverish themselves and are in the facility so you want to reach out so you are naturally going to grow your eligibility and this program just isn't built for that. It isn't built for innovating at that level. So, one of the things of course that we fear is that many of the recipients will become ineligible, many of our residents will no longer be eligible for Medicaid, or that many of the programs and services will be cut. But, also we fear that they wouldn't be cut and that you would expand the program and keep everyone as a recipient and then provider's reimbursement would shrink because if you only have so much money and you expand the services and expand the number of people that are going to become eligible, then everything, the rates and the reimbursement has to shrink and the resources, become very sparse at every level. To be realistic about it you can't provide quality services at every level of the continuum with resources shrinking at every level. So, that's a concern also. So, you really need to have a system where you're indexing adequate funding to take this all into consideration and I want to specifically address nursing facilities because they are an extremely important part of the continuum and we see the need for skilled beds is going to be there for some time to come and we want to make sure that the beds that we have are the highest quality, meet and exceed regulations and also meet and exceed resident and family expectations. Right now we're in a crisis level with the reimbursement rates and it being such a big piece of the budget, the reimbursement, the cap, the block grant that we'd

get, we see that funding to be at severe risk and that would really really affect the quality of the skilled beds that we have. So, that's of great concern. Another concern is that when you're capping the whole program at such a low rate no one wants to find elderly services by taking away your children's health care services and vice versa, so you don't want to set up a system where you have this generational conflict just growing within the state. You don't want to set yourself up for that. It would serve no benefit to anyone and as we look at how we're funding long-term care, because we really want to change the delivery of long-term care, the way that people receive long-term care and how it's perceived, we really have to look at sharing private and public funds and we have to look at ways to incentivize people to invest in the long-term care for the future. Right now there's disincentives and there's punishments and it's really not working and we really have to look at ways where people will receive federal incentives through tax credits or whatever to start thinking about investing in their long-term care – there's a sharing of private and public funds, even if it's a sharing at the same time, even if there's a cost sharing, so that you're not forcing people to become impoverished to pay for their long-term care. One thing that we thought of when we were reviewing all of this is that really what the federal government is trying to do is step back and say “you handle it” to the state. One of the things you lose in that is your advocacy of your federal delegation which we have found to be very helpful in trying to change the system and move the system in various ways, invest in areas we think should be invested in in health care. But you lose a whole sort of section of advocates that you have for you as a provider to try to change the system. So, it's just another piece there that's a concern to us that you disassociate the whole federal government, it's not just the Administration, it's your whole Congressional Senate delegation. So, there are just some of our thoughts on it.

Barbara Hunt, Medicaid Consumer

Hi. I don't have anything planned. I wonder if people can hear me? I'm having trouble getting under the desk here, so is the mic picking it up? I don't have a speech planned. I can only speak from my heart. I'm one of those optional people on Medicaid. I'm optional by \$27 a month, pushed me over into the optional category. I fear the word “flexibility” because in my mind, in my heart, I hear the rest of the equation that is flexibility to cut services. For me personally services and Medicaid have already been cut so dramatically that it's affecting my physical and emotional well being at this point. I'm also on a plan to achieve self-support, meaning in a short period of time I anticipate being off the system and a taxpaying citizen. If we see any more cuts and if that optional comes through, which really equates cuts for people like me in a variety of ways, I can honestly foresee myself becoming so debilitated health wise that it could prohibit me from even moving off the system. And there's many many ways these cuts are hidden and not revealed

to the public. So, we're already seeing cuts, people like me. It's already taking its toll. I'm open to questions, I don't have anything so specific to say. My fear again is the area of cuts that could increase and would affect me personally. I'd be happy to speak about that if people want to know more about that. Thank you.

(Audience claps)

Patricia Baker, President & CEO of the Connecticut Health Foundation

What we'd like to do now is open it up to your questions. There's been a great deal of content, I think, and really significant dilemmas presented to us at this point in time and I appreciate and want to thank everyone, the speakers and the panel. This is your time to ask questions. We'd ask you to speak, the questions should be directed on the Medicaid reforms that are proposed and your chance to really quiz and get some of that detail if there is any detail to be had from the speakers. I'd ask that you identify yourself. We're transcribing this event because as you see the paper in your packet says "draft." So, the questions and comments can be incorporated and the thoughts that are raised today can be incorporated in a final document that will be produced. Please identify yourself and I think there's a microphone available, so I open it up now for your questions. There's one in the back. If you want, rather than wait, you can also come up here to the microphones. Please feel free to come up.

Debbie Barisano, Connecticut Association of Personal Assistants

Hi. My name is Debbie Barisano, I'm a personal assistant and the Coordinator for the Connecticut Association of Personal Assistants. Just to give you a little explanation, a personal assistant is somebody who supports people with disabilities to live more independently in the community. I'd like to just make two comments. One, I'd like to applaud something that David Parrella said, which was, "when are we going to get away from the waiver system to fund people to live independently in the community versus the entitlement system for people to live in the nursing homes." Also, I'd just like to say that I'm one of those uninsured people. I have a job where I don't have access to health benefits and I have really two choices, one is to live at risk in the community as you saw in one of those graphs, somebody who does not go to doctor visits, does not get the usual Pap Smear, breast exam, because I can't afford it. My other option is to leave a job that I love that does not give me health benefits, to go into a job that I really am not happy in and I came from a job in the corporate world making \$65,000 a year and one thing that people really need to understand is while I was in that job, I was sick all the time. I used all my sick time because I was so stressed out and so unhappy that I was at doctors visits all the time. I was taking medications for asthma, and my health costs were way up. Since I've become a personal assistant, I average, at most, two sick days a year. I'm on less

medication for asthma and things like that, so my health costs have gone down and really not because I don't have access to it, but because I'm happier and not sick all the time.

Patricia Baker, President & CEO of the Connecticut Health Foundation

Thank you. Next question. Please, feel free to come up to the table while someone's asking, if you want to come up to the middle table while someone's asking so we can keep the flow going, that would help.

Bob Slate, Executive Director of COHI (Connecticut Oral Health Initiative)

I'm Bob Slate, I'm the Executive Director of COHI, the Connecticut Oral Health Initiative. First, if I could ask a question, how many people brushed this morning (crowd laughs). And I'm not including brushing your hair. The question I have is oral health is often overlooked in analysis of overall physical health and yet cavities are the most common infection among children in Connecticut. My question is how do the proposed changes in Medicaid affect the delivery of oral health services to adults and to children in Connecticut, and how is the state planning to respond to those changes for both adults and children who definitely need financial support in order to maintain healthy teeth and gums and mouth? Thank you.

Patricia Baker, President & CEO of the Connecticut Health Foundation

Cindy and David you can talk about overall – Cindy, nationally in terms of the federal, and David, if you want to make a comment.

Cindy Mann, Research Professor at Georgetown University's Health Policy Institute

OK, let me take a stab at it, and Joan, if you have something to add on the federal. The details are still evolving. In general the way the proposal looks right now is that children's benefits might not be affected, even dental benefits that are otherwise considered an optional benefit for adults, but that would remain to be seen as to how it would be affected in terms of direct benefit coverage. In terms of a zero sum gain and the cap on federal dollars and how much actually, would there be an access problem if the rates paid to dentists who serve children were changed. That's certainly an up in the air question. For adults my guess is a lot of state Medicaid directors might say "hey, that's the first thing that's being cut around the country now, so maybe this will give us a chance to save adult dental benefits or restore adult dental benefits." It is right that dental benefits is a benefit that's being cut regularly around the country, I think for reasons you stated in terms of somewhat of a lack of appreciation of the integral nature of the benefit. Um, one issue that we didn't talk about specifically in terms of impacts of a capped payment, though, is what we saw during the last recession was

a lot of states cut adult dental. It's sort of a routine. They cut adult dental and then it produces a lot of problems and there's a lot of activity to restore it and when the economy improves, most of the states that cut adult dental restored their adult dental. Under a capped payment, if a state does not get any additional federal dollars if it chooses later on when the economy improves to take steps to restore benefits and coverage that it cut in the past as long as it's already spending its full allotment. So, I think that it's already a targeted benefit now but under a cap payment system I think there would be definitely additional fiscal stress that would make it less likely that restorations would occur in the future.

Patricia Baker, President & CEO of the Connecticut Health Foundation

David, do you want to make any comment? OK, next question.

Denita Smith, Medicare and Medicaid Consumer

Hi. My name is Denita Smith and I'm one of the dual eligibles – I'm qualified for both Medicare and Medicaid. I just wanted to make one comment and I have one important question. Dave Parrella, when you were talking about the difference, you had several statements you made and you said the states need to have the ability to allow for clients to self-direct their health care. I think that's really crucial because I do a lot of self-advocacy and I'm here a lot and I'm trying to see some of these changes, but what I'm more interested in is how this is going to impact Connecticut and myself and my family – I have two teenage children. You said Connecticut has the higher than average obviously optional people, spending habits, and disabled and elderly and I see this again in my advocacy. Because they have this higher than average, than other states, at the end of this block grant, if it's passed, if it goes through the legislature, how is the state of Connecticut likely to handle the surplus of needs, or the surplus of care that's going to be at the end because we know, on our end, the consumer end, that there's a crisis now, that there's a surplus of need versus what we're given access to now. What are the odds that Governor Rowland is going to be around to pull up state money and hand it to those of us who are in great need? In your research, because you did a fabulous job doing this, did you see any indications that there would be any money coming forth to back up the state in this situation?

David Parrella, Director of Medical Care Administration for the Connecticut Dept. of Social Services

Well, that's a tough question. Speaking specifically to the question you're talking about with the flexibility. We constantly hear requests from consumers that we haven't had a very good answer for, which is that a lot of the systems we have in place to cover services, the traditional service delivery mechanisms, whether it's through homecare agencies or nursing homes, isn't really what families want a lot of times. A lot of families want

the ability to be able to use funds to self-direct care through hiring people in their community that they want to train and they want to use, I'm talking more specifically about home care than clinical care, that's a national trend. We haven't done, in my opinion, enough of that and I think we need to do a lot more, whether it's...

(TAPE 1 SIDE B ENDS)

... that we have in place right now just doesn't work. We see this on a daily basis where requests will come in for homecare, even if we approve them for eight hours a day, the families can't find homecare agencies to staff them. We have approved commitments to pay and we can't staff the hours of care because I think, as everybody knows, there's not a super abundance of nurses out there right now, or home health aides. So, I think a lot of the solution, not all of the solution, but a lot of the solution in terms of service delivery has got to be moving toward less traditional clinical models of care, particularly for families struggling with these issues in the community. In terms of where it's going to go with funding, I don't have a crystal ball. I'm on the phone pretty constantly these days, talking about budget negotiations, just what we're struggling with for the next two years. Again, I go back to my comment and I don't mean to sound uncaring about this, but there is a limit toward, and I think if everyone is really honest with themselves, it's not just state bureaucracies that have that limit, there's a limit in terms of what percentage of the state general fund the Medicaid program is going to be able to pay – we're at between 20 to 25 percent of the state general fund right now. So, every time you pay a tax dollar to the state, somewhere between two dimes and a quarter of that tax dollar is paying for the Medicaid program. Should it be more? Certainly the issues you're raising are that the need is there, all the stories we've heard, the previous question back there, the issue of the uninsured, God knows, we've done well compared to other states, we're always ranked second or third lowest in the percentage of the population that has no health insurance, but that still is 8 to 9 percent of our population. And, in terms of the people that have coverage, your situation, are we fully meeting the needs of those folks? Probably not. But, my point is whether this happens or not, whether we have a federal match or an allotment, and if an allotment is available, whether Connecticut chooses to take it or Connecticut chooses to stay with its current system, you still have a problem with how do you appropriate dollars here in this house, not in Washington, in this house. I mean, it's very easy to point the finger at DC and say, oh, those people in Congress, look what they're talking about doing. We have to look in the mirror a little bit about what we value in terms of the appropriations from here. Sure, we'd like to provide more oral health care, sure we'd like to make sure that our nursing homes are adequately compensated, that people like Bridgeport Hospital that take care of large numbers of undocumented

citizens for which they get no reimbursement, that they get supported, but what's your priority for state budget spending? Do you want Medicaid to become 40 percent of your general fund and not support the University of Connecticut? Do you want to not support your state highway system? There is, whether we acknowledge it or not, there is some limit that we have to work under. I have a very selfish perspective, I happen to think Medicaid is the most important program, I'm not sure everybody agrees with me.

Cindy Mann, Research Professor at Georgetown University's Health Policy Institute

If I could just make one response to that, which is, I think, you know, both the question and David's response underscores where there's actually a lot of commonality and sense of solutions. I think there's nothing that distinguishes us here, this morning, in terms of any of the presentations, with respect to some more responsibility has to be picked up by the feds and the increase in the matching rate, the temporary increase in the federal matching rate that just was enacted was a small step towards that. There may be some bigger steps or smaller steps towards that and the Medicare prescription drug bill. But I think that no one would dispute that there's a crisis now, and one that will continue to grow as the population ages. And it is terribly important to think about what's the appropriate level of government to absorb some of the costs of health care coverage, both the coverage that's now provided as well as the coverage that's needed for people who don't get care. I think that our analysis of the block grant shows to us that capping the federal dollars and letting the feds walk away from a big portion of that set of problems is not a productive way to go for states or beneficiaries and communities, but there really does have to be a collective effort to look at more constructive solutions.

Patricia Baker, President & CEO of the Connecticut Health Foundation

Next question.

Sheila Ander, National Alliance for the Mentally Ill in Connecticut

Good morning. My name is Sheila Ander from the National Alliance for the Mentally Ill in Connecticut. I wanted to pick up on something that David said which I absolutely agree with, that we don't really know what we want Medicaid to be. I would suggest to all of us in Connecticut that we're in a very, very good position to re-think our Medicaid program right now, but only in relationship to an overall state health care policy because we make decisions in this state that have unintended consequences that increase costs and I'm going to give you a couple of examples. Cindy mentioned we have high nursing home costs. We also have high nursing home populations for the area I know best, people with severe mental illness, we have

2,500 people when we last counted and I think it's higher now of people with severe, serious mental illness in nursing homes, half of whom are under 65. If you think of what we spend on that it's \$60,00 to \$70,000. I don't know, David, what the average Medicaid cost is, so, my first question is why are we doing it? And, if we had a policy or a programmatic approach that crossed departments in terms of planning we would say, "how do we fund a home- and community-based system of care using Medicaid as a financing tool, reinvesting the dollars that we're now spending in places like nursing homes and prisons and juvenile detention and residential treatment and on and on. We love institutions in Connecticut." If we looked at that, I think frankly we would cut the rate of spending of Medicaid, instead, we segment our decision making and I know there's an effort on the behavioral health side to change that, but we segment our decision making about health care and we get those unintended consequences and I think, frankly, we could do that under existing Medicaid policy without having any change at the federal level, so it was more a statement than a question but you might want to comment.

David Parrella, Director of Medical Care Administration for the Connecticut Dept. of Social Services

Well, Sheila, and I have been talking about these issues for a long time. I'll give you an example. In federal statute right now there's this thing called the IMD (Institutions for Mental Disease) exclusion. What that says is that if you're in a facility whose primary reason for being is the treatment of persons with what they categorize as mental disease, which could be behavioral health, substance abuse, and facilities larger than 16 beds, then not only is Medicaid funding not available for that service, but that person is ineligible. Now, what sense does that make? Well, it made sense to Congress back in 1965 when states used to operate big state mental health systems and this was their way of reversing maintenance of effort. They didn't want to suddenly turn all those systems to become federally funded under Medicaid, so they just excluded them. But, as Sheila correctly points out, this has consequences, for example, when we're dealing with the frail elderly and we want to demonstrate the cost effectiveness of caring for those people outside a nursing home, we have a level of care we can point to and say here's the cost. It's much more cost effective to care for people in the home. If you're talking about institutions for mental disease and you come in and say I want a community-based waiver to counteract this, it's not there, the feds have never recognized it. Now, that is not a state problem. That's a problem at the national level. There are clever things that we can do and are trying to do in the state to try to use the rehab option and other means of creating group residences for people that might fall underneath that 16-bed limit so we can get federal matching funds. But, those are problems that are inherent in, it's the current

Medicaid system, I can't say this strongly enough. It was created with bias towards institutional care and bias against behavioral health. It's been there since the law was passed in 1965 and it's never gone away and a lot of the efforts going on are trying to counteract that. I hope we're making some progress but I don't think we've done enough.

Patricia Baker, President & CEO of the Connecticut Health Foundation

OK, there's a gentleman in the back that's been waiting. Then, the next speaker up here.

Larry Deutsch, Pediatrician and Public Health Researcher

Thank you. I'm Larry Deutsch, a pediatrician and public health researcher in this area. I'd like to turn for a moment to questions of universality of care and quality of care. An example I'd like to begin with is here in the city of Hartford, it's been determined that so many children are in need of assistance that all children get school lunches rather than discriminating among those 80 to 90 percent that are eligible by certain standards. It's been felt that the administrative simplification has been worthwhile, such that each and every child in Hartford does not have to pay for school lunch. Now, extrapolating that somewhat, let's say to the case of dental care, it's also fairly clear that there are many children in Connecticut who lack adequate access to dental care. It differs by parts of the state and eligibility and other categorical determinations, as issues of quality in dental care and then generalizing to EPSTD and other standards, even something as simple as immunization, all those we feel for the sake of quality and health have universal application. So, the question I'd like to raise is this, what calculations have been done, not just on the federal level, but in particular applied to Connecticut and in particular by the way digressing for a moment, to the comment that Connecticut has been doing fairly well in relationship to other states. The phrase "two Connecticuts" is fairly well known by now I think, that there are two Connecticuts and the health care status and access is vastly different in different sectors of our state and focusing on children that's especially applicable. To what extent have there been calculations of the administrative simplification savings made in various sectors to truly extend universality either to whole segments of the population, let's say all children under 18, or for certain services, say dental care for all children, or limiting, if one must, universality for children whose families have income below the median for the state, in other words, broad categories of services in terms of eligibility, quality, scope of benefits such that much of the administrative waste is eliminated. I know the calculations have been done in certain cases and again I'm proud to say in Hartford it's been felt that a universal program was well worth it and for that case in deed for school children there is a free lunch. But, going ahead, then, the question to researchers and legislators here in Hartford is look-

ing at the administrative complexity, in particular of our current system and that proposed at the federal level and at the shifting to block grant and then as has been often mentioned the need to discriminate among eligible populations and so on, let's look at the administrative waste.

Patricia Baker, President & CEO of the Connecticut Health Foundation

I'm going to ask Cindy and David if in fact there's any modeling that has been done. And, I want to be very respectful of time, so we have a few more questions and then we'll close. David?

David Parrella, Director of Medical Care Administration for the Connecticut Dept. of Social Services

I don't think there's an easy answer to that in terms of administrative modeling, but, just a personal experience, and I just have to give Cindy Mann here tremendous credit for her leadership on, when we moved to implement the S-CHIP legislation and when Cindy was our leader in Baltimore and those folks did a tremendous job, I think we all saw a lot of good efforts in Connecticut and other places to go out and identify and enroll children that were newly eligible under those programs. You can just think about the rationality for yourself in terms of if a child was born in the country and they didn't have to be contacted and they didn't have to be enrolled and they didn't have to be re-enrolled on a regular basis. Because the goal, when you're covering children as we do in Connecticut, to 300 percent of poverty, there's not that many kids that you're not going to find who wouldn't come under some sort of eligibility who might not otherwise have private insurance. But, we spent a lot of time and effort trying to find them. So, that's just an example but I can't give you quantified costs.

Patricia Baker, President & CEO of the Connecticut Health Foundation

Cindy, do you want to add anything to that, or Joan?

Joan Alker, Senior Research at Georgetown University's Health Policy Institute

I was just going to say that there was legislation introduced a few years ago by Congressman Stark from Connecticut which would have provided universal coverage for kids, they would have been enrolled upon birth, so there may have been a score attached to that which would have some analysis of those costs, so, we could check on that.

Cindy Mann, Research Professor at Georgetown University's Health Policy Institute

There have been some experiments, too, in Santa Clara County in California they are enrolling all children, it's a universal coverage and part of what they're looking at is how much they are

saving in terms of, you know, getting rid of the effort to differentiate. I worry however that at the federal level there's increased momentum to push states to make sure nobody is ineligible who's in the program and that we're going to have some incentives at the federal level to push states in the wrong direction so we need to be vigilant about the importance of keeping some progress going on the fronts, a lot of the improvements Connecticut has made and many other states and not go backwards under the name of program integrity.

Patricia Baker, President & CEO of the Connecticut Health Foundation

OK, next question.

Sheldon Talbot, Medicaid Advocate with New Haven Legal Assistance Association

Thank you. My name is Sheldon Talbot, I'm a Medicaid advocate with New Haven Legal Assistance Association. I have a couple questions. First, for Barbara Hunt, whose story I thought was pretty moving I thought in terms of being an optional Medicaid recipient. We already have dollar co-pays that were recently imposed that are causing a lot of problems. People, for example, are not getting psychiatric meds and just not following up with that. What would happen if under this proposal the commercial standards for coverage and particularly for cost sharing, like co-pays, were imposed on you as an optional Medicaid beneficiary, so take for example, a \$15 co-pay each doctor visit, or a \$15 to \$25 each time you had to get a prescription drug. That's my question for Ms. Hunt. And, if I could ask another question. David said that everyone agrees that the Medicaid program could use more money, needs more money, I agree with that except I'm not sure it's everybody. I think it's long been a cherished goal of radical conservatives to do away with all federal entitlement programs and this in fact is not the first time we've heard of the proposal to block grant the Medicaid program, going back to the time of the block granting of the welfare program, it was also proposed to block grant the Medicaid program at that time and I think largely because of Bill Clinton that did not happen. But, it's important to emphasize that that proposal was pushed during flush times so it had nothing to do with being driven by budget crisis in the states. Now, in light of, I believe disproportionate power among radical conservatives in Washington, we're hearing this all over again, and the first shot across the bow was the January 16 letter signed by Governor Rowland and Governor Bush and Governor Owens written to President Bush saying very starkly on page two of that letter, it's time to "move away from entitlement without responsibility" under the Medicaid program, as if people are responsible, I guess, for getting sick. But, the point is this has been a long cherished goal and now that times are hard, financially in the states, it's being used, I think, in part as the excuse to push the block granting. So, my question is this,

in terms of what we're seeing now, in this proposal, how does it relate to what happened in 1996? Obviously the politics are different, but are the terms of the proposal significantly different?

Patricia Baker, President & CEO of the Connecticut Health Foundation

I'd like Barbara first to speak to the first question then we'll have one more question.

Barbara Hunt, Medicaid Consumer

I hope I can remember it. Well, I think, what I'm thinking right now is the out-of-pocket cost for prescriptions that was imposed, the dollar amounts, already hits me and I know there is an exemption somewhere but what I didn't expect was multiple prescriptions and also a lot of pharmacy items that are not prescriptions. I didn't realize that I'd have to pay for myself, normal saline for cleaning comes from a pharmacy, a lot of personal items come from, are paid from Medicare but come from the pharmacy rather than durable medical. So, all of these costs, all of a sudden in a week \$10 to \$15 a week spending on items I'm paying out-of-pocket already for inferior durable medical supplies that I have a choice whether I want to pay out-of-pocket for a higher grade something or other that's supposed to help me and you know, I have to choose my health. So, now if we begin to impose out-of-pocket for doctors and whatever, now I'm way under, my income would drop substantially that I wouldn't be eligible for the mandated Medicaid and I'd still be optional, so what would happen, I'd have to pick and choose what is more important for my health.

Patricia Baker, President & CEO of the Connecticut Health Foundation

Cindy, Joan, any comment?

Joan Alker, Senior Researcher at Georgetown University's Health Policy Institute

I just want to make a quick comment that ties together your two questions. I think Barbara very eloquently demonstrates that these categories, the mandatory versus optional, are sort of artificial in real life. This is a fiction that essentially has been created by federal law changing over time because Medicaid has been around for almost 30 years now. To me one of the significant differences from the 1995 effort to block grant which both Cindy and I were involved with at that time, to oppose that proposal. Now it's described not as a block grant – it's just about optional beneficiaries and optional services, which makes it sound a lot more benign. But, of course for the person who needs that service it's not optional. For someone who's \$27 over the limit, that distinction is not very meaningful, so I think that's a very important way in which the language of the proposal has changed in policy discussions, but for people in the real world, it has the same impact in many respects.

Patricia Baker, President & CEO of the Connecticut Health Foundation

Any other responses from the panel? OK, thank you. Next question and then we're going to have to close.

Gretchen Vivier, Director of the Health Care for All Coalition

I'm Gretchen Vivier, Director of the Health Care For All Coalition and I just wanted to applaud what David said in the very beginning is that we should all feel ashamed if there are people among us that don't have the same benefits we do and we should do something to change that and if that requires that some people have to contribute more, in the state of Connecticut for instance, we're trying to get revenues from people with higher incomes and have them pay at a higher rate. Anyway, that would be an important contribution so that all of us could have the same benefits and the same kind of health care in this case and education, housing and so forth, that instead we've come to a society that doesn't value that, that doesn't feel ashamed when they have too much. So I applaud that idea and I hope you pass that along when you're talking about budget negotiations.

Patricia Baker, President & CEO of the Connecticut Health Foundation

Thank you, thank you very much. I'm sure there are more questions and I apologize, ok, I'm sorry my back was to you, OK, one question because my back was to this group.

(Question inaudible – speaker not near microphone)

Cindy Mann, Research Professor at Georgetown University's Health Policy Institute

The state revenue systems are not responding well to the recession for a couple of reasons – one is there is a recession, there's less money, less income, and so revenues that states had been seeing coming in at record high rates have been dropping at record low rates. Secondly, the National Governor's Association, as well as others who have looked at the state revenue system, have pointed out there are some inherent problems in state revenue systems that then exacerbate the problems that every state is facing. In terms of how progressive their income tax is, in terms of their changing to a service economy and whether or not on a sales tax they're taxing goods and not the things people are buying which are services, in terms of losing revenues from Internet exchange. So there are a lot of state tax reform issues that are part of what's going on in terms of the state revenue decline. So you see, you talk of two worlds in Connecticut, there are sort of two worlds in terms of what's going on with the states versus the federal government. The federal government is doing massive tax cuts and states are seeing their revenues decline for a variety of reasons and there also

needs to be some better connection in terms of questioning those conflicting policies. There has been some analysis, if you look at the Center on Budget and Policy Priorities' website, they've done something recent that looks at the last round of tax cuts in terms of what some of the impacts will be on a state by state basis. To some degree states have some decisions to be made to decouple from some of the changes but a lot of the changes at the federal level, it would be harder for the estates to decouple.

Patricia Baker, President & CEO of the Connecticut Health Foundation

Thank you, I'm sorry we couldn't get to all of your questions. But, I do want to respect your time. I want to introduce Juan Figueora, the President of Anthem Foundation, our partner in producing this event, Juan.

(Audience claps)

Juan Figueora, the President of Anthem Foundation of Connecticut, Inc.

Thank you. This is a serious subject with some serious implications. I'll come back to that in a minute. I must start by saying for those of us who are relatively new to this subject area, I think I'll drop on David's initial Peruvian experience with witchcraft in order to try to understand the system, never mind trying to resolve it. My job is to do some synthesizing of what has been talked about today and to wrap this session. I think the place to start in synthesizing what this is about is Barbara Hunt's comments and whom she represents, because ultimately, all the policy implications we're talking about here affect people like Barbara and the folks who are here who are consumers and who are dependent on this very essential program. I think that's the starting point for trying to understand what is going on with this subject and what the impact is. So, David's presentation, as you'll recall, he posed a very important question, "What do we want Medicaid to be?" He talked about the notion of limited goods. He shared a vision with us that included modernizing Medicare, more flexibility for states, simplifying eligibility standards, and not losing sight of the fact that it is ultimately an entitlement to patients, not to providers. We heard from Joan, a very important point, one of the reasons we're here is because our governor is an active participant and a major player in these debates in Washington. She reviewed the President's proposal and one of the important pieces of the President's proposal, as you'll recall from her presentation, is the fact that it's a cap on the optional federal spending in this program, which accounts for two-thirds of the Medicaid spending. We heard from Cindy Mann on the impact of this policy, the potential impact on Connecticut. She talked about four risks, the first one, the fact that Connecticut has a higher share of that optional spending, two, the basis for future funding is in part,

according to the formula being proposed, dependent on your historical costs. Historical costs for Connecticut are low, yet she told us it is not a valid predictor for how much you'll end up spending on Medicaid in the future. Third, she talked about the fact that, as a block grant, the fiscal incentives are going to be changed so that it won't encourage investments and four, she talked about the zero gain, because Connecticut has a higher proportion of costs for the elderly and disabled, in the end if you have to cut, where is it going to come from and are you pitting one against the other? Finally, she talked about paying attention to details, which is part of why we're here today and the fact that Medicaid has in fact worked for a lot of people. So, I want to mention a couple things about the panelists, I took note of the fact that it was a representative from the Connecticut Hospital Association who gave us the example of the United States not having a universal health care system. That's an important piece of information coming from an important messenger in this context. So, where does this leave us and where do we go next? I would sum it up in this fashion – this is a key issue in a key state with a key governor who is playing a key role in shaping both the debate and the final outcome of what is going to happen with the Medicaid program going forward. So, the interest that has been both laid out here today in terms of the people that you've seen is going to continue. There's a group of people that want to give out the information to the public, shed some light on what's happening, there's a group that I think has come together informally and I think will probably be more formalized as this goes forward, that will consider ways in which we need to inform the public, meet with our congressional delegation, talk to editori-

al boards so the message can get out in terms of what does this represent for the residents of the state of Connecticut. And, the contact person is Judy Solomon, so if you have any desire to be part of this or any questions as we move forward, please get in touch with Judy. So, I also want to mention that within the next few days we, the Anthem Foundation, will be putting out a report, it's actually a study that will show you how cuts to Medicaid actually impact, obviously the uninsured, but then how those costs get shifted to both employers and employees and eventually those of you who have insurance policies. With that I'd like to first thank all of you for attending and I want to make special mention of the elected officials who made it a point to be with us. I see my former colleague here, Jack Thompson, who's been a great champion of these issues for many years, thank you Jack for joining us. Pat Dill I know was just here, Vicki Nardello and David McClusky and Senator Kathy Cook as well, so, one last set of thank yous obviously for the panelists for joining us. If you can join me in applause for them. (Audience claps). And, finally a thank you to Judy Solomon for taking a lead on these issues, Pat Baker from the Connecticut Health Foundation, her staff who did a great job, Judith Shea, my staff who worked in conjunction, and let's make sure that this issue is alive and well in the public mind so that we can shape it for the future. Thank you.

(Audience claps).